

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>					d. STREET ADDRESS <u>987 McMullin Highway</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EVA</u> Middle <u>P</u> Last <u>AMICK</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>5</u> Year <u>1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Sept. 29, 1897</u>		9. AGE (In years last birthday) <u>68</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Ellerslie, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Perry Lowery</u>		14. MOTHER'S MAIDEN NAME <u>Mary Logsdon</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-01-5481</u>	
17. INFORMANT <u>Miss Francis Amick, Cumberland, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL THROMBOSIS AND DIABETIS MELITUS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from <u>8-29-</u> , 19 <u>63</u> , to <u>5-5-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-4-</u> , 19 <u>66</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.		22a. SIGNATURE <u>Eugen A. Ramirez</u>		22b. DATE SIGNED <u>5/5/66</u>		22c. PHYSICIAN'S NAME (Type) <u>EUGEN A. RAMIREZ, MD</u>	
22d. ADDRESS <u>1500 Penca Ave-Hagerstown Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 8, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Everett Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Everett, Bedford Co., Pa.</u>	
24. FUNERAL DIRECTOR <u>Harvey H. Zeigler</u>		25a. REC'D BY REGISTRAR <u>MAY 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. HYNDMAN, PA.		25d. REGISTRAR'S SIGNATURE	



2153

*[The following text is extremely faint and largely illegible. It appears to be a series of lines of text, possibly a list or a document, spanning the majority of the page. Some faint words like "and", "the", and "of" are visible.]*

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2  
MEDICAL CERTIFICATE

# MEDICAL CERTIFICATION

2

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9

**MARYLAND STATE DEPARTMENT OF HEALTH**

## CERTIFICATE OF DEATH

07550

1. PLACE OF DEATH a. COUNTY <div>Washington</div>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <div>Maryland</div> b. COUNTY <div>Allegany</div>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <div>Hagerstown</div>		c. LENGTH OF STAY IN 1b <div></div>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <div>Western Md. State Hospital</div>		d. STREET ADDRESS <div>Rt. # 5 Winchester Rd.</div> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div>Clice marvin</div>		4. DATE OF DEATH Month <div>May</div> Day <div>5</div> Year <div>1966</div>	
5. SEX <div>Female</div>		6. COLOR OR RACE <div>White</div>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div>Jan. 1, 1895</div>	
9. AGE (In years last birthday) <div>71</div> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/> Months <div></div> Days <div></div> Hours <div></div> Min. <div></div>	
11. BIRTHPLACE (County & State, or foreign country) <div>Charles Town, W. Va.</div>		12. CITIZEN OF WHAT COUNTRY? <div>U.S.A.</div>	
13. FATHER'S NAME <div>Thomas L. Rissler</div>		14. MOTHER'S MAIDEN NAME <div>Lorenza Yates</div>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <div>No</div>		16. SOCIAL SECURITY NO. <div>None</div>	
17. INFORMANT <div>Mr. Clarence Athey</div>		Address <div>Cumb., Md. Rt. #5 Winchester Rd.</div>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div>BRONCHOPNEUMONIA</div> 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) <div>BILATERAL PULMONARY EMBOLUS</div> DUE TO (c) <div>CVA and GEN. ARTERIOSCLEROSIS</div> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <div>DIABETIS MELITUS</div> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <div>1 WEEK</div> <div>UNKNOWN</div> <div>UNKNOWN</div>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <div></div> p.m. <div>19</div>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <div>April 18, 1966</div> to <div>May 5, 1966</div> , that (I) <del>was</del> last saw the deceased alive on <div>May 5, 1966</div> , and that death occurred at <div>7:30 PM</div> , from the causes and on the date stated above.			
22a. SIGNATURE <div>Efren A. Ramirez</div>		22b. DATE SIGNED <div>5/6/66</div>	
22c. PHYSICIAN'S NAME (Type) <div>EFREN A. Ramirez, M.D.</div>		22d. ADDRESS <div>Western Md. State Hospital Hagerstown, Maryland</div>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <div>Burial</div>		23b. DATE THEREOF <div>5/8/66</div>	
23c. NAME OF CEMETERY OR CREMATORY <div>Hillcrest Burial Park</div>		23d. LOCATION (City, town or county) (State) <div>Cumberland Md.</div>	
24. FUNERAL DIRECTOR <div>H. Wayne George</div>		25a. REC'D BY REGISTRAR <div>Charles Judge</div>	
25b. REGISTRAR'S SIGNATURE <div>Charles Judge</div>		DATE <div>MAY 10 1966</div>	

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Office Memorandum  
May 1, 1942

May 1, 1942

W. A. R. R. R. R. R.

MAY 10 1942



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
07560 CERTIFICATE OF DEATH 07551

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN b <u>9 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown 21-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>R # 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sophia</u> First <u>Margaret</u> Middle <u>Baker</u> Last		4. DATE OF DEATH <u>May</u> Month <u>18</u> Day <u>19</u> Year <u>66</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 3, 1895</u>		9. AGE (in years last birthday) <u>70</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Riedel</u>				14. MOTHER'S MAIDEN NAME <u>Susan Morganthall</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-10-3940</u>		17. INFORMANT <u>Mrs. Phyllis Harshman R # 3 Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> OUE TO <u>nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } OUE TO <u>generalized arteriosclerosis</u> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, hypertension; obesity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>yrs</u> <u>yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. none 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) - - -	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>63</u> , to <u>May 18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 17</u> 19 <u>66</u> , and that death occurred at <u>AM</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Harold R. Tritch, Jr.</u>						22b. DATE SIGNED <u>5-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Harold R. Tritch, Jr.</u>				22d. ADDRESS <u>302 N. Potomac Street Hagerstown, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/20/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Hunt</u>				25a. REC'D BY REGISTRAR <u>MAY 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
24. FUNERAL DIRECTOR <u>Rest Haven Funeral Chapel</u>				24. FUNERAL DIRECTOR <u>Hagerstown, Md.</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07552

07552

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>60 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>916 KUHN AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LUCILLE</b> Last <b>BARNES</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>6</b> Year <b>1966</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/8/1898</b>		9. AGE (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FINTON MIDDLEKAUFF</b>				14. MOTHER'S MAIDEN NAME <b>LAURA ORRICK</b>				Address <b>HAGERSTOWN MD.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-16-0213</b>		17. INFORMANT <b>MR. NORMAN O. BARNES</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma gall bladder -</b> DUE TO (b) <b>Metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <b>8 Mm</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>May 25</b> , 19 <b>66</b> , to <b>May 6</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>May 5</b> , 19 <b>66</b> , and that death occurred at <b>12:30</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Edward W. Ditto III</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>5-6-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto, III, M.D.</b>				22d. ADDRESS <b>217 W. Washington Street, Hagerstown, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/9/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BEAVER CREEK CEM.</b>		23d. LOCATION (City, town or county) (State) <b>WASHINGTON COUNTY MD</b>			
24. FUNERAL DIRECTOR <b>W. J. Norment Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07562					07553				
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>42 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>233 Alexander St.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>233 Alexander St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Daniel</u> Last <u>Barnhart</u>			4. DATE OF DEATH Month <u>May</u> Day <u>16</u> Year <u>1966</u>						
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 31, 1885</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>21</u> Days <u>1</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Concrete Mason</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Williamsport, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>William Harvey Barnhart</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Alice Pence</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>214-09-2742</u>		17. INFORMANT <u>Mrs. Fannie Barnhart</u>		Address <u>Hagerstown, Md.</u> <u>233 Alexander St.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Of Stomach</u> <u>151X</u> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Vascular Disease, Severe</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that (I) (this hospital) attended the deceased from <u>1-2-66</u> , 19 <u>66</u> , to <u>5-16-66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-16-66</u> , 19 <u>66</u> , and that death occurred at <u>8</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>A. E. W. Ditto, Jr.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. _____			22b. DATE SIGNED <u>5-18-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				22d. ADDRESS <u>Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/19/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>			23d. LOCATION (City, town or county) _____ (State) _____ <u>Hagerstown Md.</u>		
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u>				ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>			25a. REC'D BY REGISTRAR <u>MAY 20 1966</u>		
							25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Adelphi</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Western Maryland State Hospital</b>					d. STREET ADDRESS <b>2401 Cool Spring Road</b>						
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Henry</b> Last <b>BARRETT</b>					4. DATE OF DEATH Month <b>MAY</b> Day <b>14</b> Year <b>1966</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>2-3-1908</b>		9. AGE (In years last birthday) <b>58</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Cook</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Montgomery Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William T. Barrett</b>					14. MOTHER'S MAIDEN NAME <b>Nellie Dixon</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>					16. SOCIAL SECURITY NO.					17. INFORMANT <b>Lester A. Barrett</b>	
					Address <b>4703 25th St. Mt. Rainier, Md.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CAACINOMA OF LUNGS</b> <b>163X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (the hospital) attended the deceased from <b>3-11-</b> , 19 <b>66</b> , to <b>5-14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-14-</b> , 19 <b>66</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Antonio U. Pallagrosi</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5-14-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>ANTONIO U. PALLAGROSI</b>					22d. ADDRESS <b>1500 PENNA AVE HABERSTOWN</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>5/17/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>				
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>					25a. REC'D BY REGISTRAR <b>MAY 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b> c. LENGTH OF STAY IN 1b <b>—</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GARLOCK MEM. CONV. HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Franklin</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STATE LINE</b> d. STREET ADDRESS <b>STATE LINE, Pa.</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>J. Allen Binkley</b>		4. DATE OF DEATH <b>MAY 27 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/10/1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARM - Owner + operator</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Mason-Dixon, Pa.</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Binkley</b>		14. MOTHER'S MAIDEN NAME <b>Margie Barnhart</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>204-30-6500</b>	
17. INFORMANT <b>Mrs. Lillie M. Binkley</b>		Address <b>State Line, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>possible cerebral metastasis</b> DUE TO (b) <b>uremia and anemia</b> DUE TO (c) <b>carcinoma of prostate</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>bronchopneumonia and diabetes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1963</b> , 19 <b>—</b> , to <b>death</b> , 19 <b>—</b> , that (I) (we) last saw the deceased alive on <b>May 25 1966</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John C. Stauffer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>A. E. Minnich - Greencastle, Pa.</b>		25a. REC'D BY REGISTRAR <b>MAY 31 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>			

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STATE OF NEW YORK

IN SENATE  
JANUARY 10, 1884

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1883

ALBANY: J. B. LIPPINCOTT & CO. PRINTERS.

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NEW YORK: J. B. LIPPINCOTT & CO. PRINTERS.

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NEW YORK: J. B. LIPPINCOTT & CO. PRINTERS.

1884

NEW YORK: J. B. LIPPINCOTT & CO. PRINTERS.

1884

NEW YORK: J. B. LIPPINCOTT & CO. PRINTERS.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>116 Fairground Ave.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bertha Effie Bitner</b>		4. DATE OF DEATH Month Day Year <b>May 13, 1966</b> 19	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 29, 1908</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cafeteria</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Berwick, Columbia Cty Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Aaron Bechtel</b>		14. MOTHER'S MAIDEN NAME <b>No Record</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>301-01-3947</b>	
17. INFORMANT <b>Mr. Roy J. Bitner</b>		Address <b>116 Fairground Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus, Severe</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/25/66</b> , 19 <b>66</b> , to <b>5/13</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/13</b> , 19 <b>66</b> , and that death occurred at <b>4:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Robert V. L. Campbell</b> M.D.		22b. DATE SIGNED <b>5/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robt V. L. Campbell</b>		22d. ADDRESS <b>Hagerstown md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/16/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Greencastle, Pa.</b>	
24. FUNERAL DIRECTOR <b>A. K. Coffman Funeral Home, Inc</b>		25a. REC'D BY REGISTRAR <b>MAY 17 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF OHIO

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NOTICE

TO THE PUBLIC: This is to certify that the within and foregoing is a true and correct copy of the original as the same appears on the records of the County of Franklin, Ohio.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07566		07557	
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HANCOCK</b>	
c. LENGTH OF STAY IN lb <b>19 DAYS</b>		d. STREET ADDRESS <b>METHODIST AVENUE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RHODA ELIZABETH BIVENS</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>7</b> Year <b>19 66</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/28/1890</b>
9. AGE (In years last birthday) yrs. <b>76</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES A. WELLER</b>		14. MOTHER'S MAIDEN NAME <b>JANE MYERS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-24-8480</b>	
17. INFORMANT <b>CLARENCE H. BIVENS</b>		18. ADDRESS <b>METHODIST AVENUE HANCOCK, MARYLAND</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Linitus plastica</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>1 (history)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fibrosis liver; coronary thrombosis, possibly terminal</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 18</b> , 19 <b>66</b> , to <b>May 7</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>May 6</b> , 19 <b>66</b> , and that death occurred at <b>5:00</b> A.M. from causes and on the date stated above.			
22a. SIGNATURE <b>W. T. Layman, M.D.</b>		22b. DATE SIGNED <b>May 9, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>		22d. ADDRESS <b>100 Professional Arts Bldg. Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5/10/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN MEMORIAL</b>	23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN, WASH., MD.</b>
24. FUNERAL DIRECTOR <b>Harold J. Hume Hagerstown Md</b>		25. REGD BY REGISTRAR <b>MAY 13 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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SYNOPSIS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07567											
Items 2, 4 File 379 8/3/66 mh											
09022											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					c. LENGTH OF STAY IN 1b 3 weeks						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS 31 E. Washington St.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Isaac First Middle Last Isaac Gruber Bomberger					4. DATE OF DEATH Month May Day Year June 31 19 66						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 28-1903		9. AGE (In years last birthday) 63 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor		10b. KIND OF BUSINESS OR INDUSTRY Merchant Marines		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days Hours Min.			
13. FATHER'S NAME Howard Bomberger					14. MOTHER'S MAIDEN NAME Ida Gruber						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 232 26 6898						
17. INFORMANT Mrs. Daisy Miller					Address 31 E. Washington St. Hagerstown Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5271 Pneumonia (b) Tuberculous Emphysema (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cor Pulmonale + old Tuberculous Emphysema										INTERVAL BETWEEN ONSET AND DEATH many years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) May 31 21. I certify that (I) (this hospital) attended the deceased from June 25, 19 65, to July 1, 19 66, that (I) (we) last saw the deceased alive on May 31, 19 66, and that death occurred at 5 P. M. from the causes and on the date stated above. 22a. SIGNATURE Edson B. Moody M.D. 22c. PHYSICIAN'S NAME (Type) Edson B. Moody M.D. 22d. ADDRESS Hagerstown, Maryland 22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF June 3-66		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town or county) (State) Williamsport Md.				
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport Md.					ADDRESS Williamsport Md.		25a. REC'D BY REGISTRAR JUN 6 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

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## CERTIFICATE OF DEATH

07558

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> 21-1	
c. LENGTH OF STAY IN lb <b>71 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>601 Maryland Ave.</b>		d. STREET ADDRESS <b>601 Maryland Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>CALVIN</b> Last <b>BOWERS</b>		4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>19 66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/27/94</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William H. Bowers</b>		14. MOTHER'S MAIDEN NAME <b>Ida M Andrews</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>717-07-9275</b>	
17. INFORMANT <b>Anna B. Bowers</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease with</b> <b>4200</b> DUE TO <b>Congestive failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Indefinite</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <b>June 15</b> , 19 <b>64</b> , to <b>May 18</b> , 19 <b>66</b> , that (I) (we) lost <b>5:25 A.</b> saw the deceased alive on <b>May 17</b> , 19 <b>66</b> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <i>B. B. Kneisley</i>		22b. DATE SIGNED <b>5/18/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		22d. ADDRESS <b>148 West Washington Street Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5/20/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) _____ (County) _____ (State) _____ <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b>		ADDRESS <b>HAGERSTOWN, MD.</b>	
25a. REC'D BY REGISTRAR <b>MAY 24 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Washington</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 Weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		<u>21-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>326 Jefferson Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CYRUS GROVER BRANDENBURG</u>				4. DATE OF DEATH Month Day Year <u>May 12 19 66</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 23, 1885</u>		9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>12 19 66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner &amp; Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hag. Motor Express</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wolfsville, Fred. Co., Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry L. Brandenburg</u>				14. MOTHER'S MAIDEN NAME <u>Louisa C. Grossnickle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs. Anna B. Brandenburg</u> Address <u>326 Jefferson St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 19 66</u> to <u>May 19 66</u> , that (I) (we) last saw the deceased alive on <u>5/12/66</u> 19 <u>66</u> , and that death occurred at <u>1:45 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Andrew K. Coffman</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/13/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Andrew K. Coffman</u>				22d. ADDRESS <u>Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/14/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hag. Wash. Co. Maryland</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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Name of Deceased		Date of Birth	
Sex		Race	
Place of Birth		Date of Death	
Cause of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Issuance	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

07570

07560

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>48 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>316 Garlinger Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lester</u> Middle <u>Jacob</u> Last <u>Britcher</u>		4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1966</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 12, 1892</u>		9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Municipal</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Gettysburg, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles M. Britcher</u>				14. MOTHER'S MAIDEN NAME <u>Anna Keith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>219-20-0462</u>		17. INFORMANT <u>Mrs. Ruby S. Britcher</u>		Address <u>Hagerstown, D.</u> <u>316 Garlinger Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanotic carcinoma of the liver</u> 1562 DUE TO (b) <u>Primary site of carcinoma unknown</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>8 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Insufficiency</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June, 1960</u> , to <u>May 26, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 26, 1966</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Edson B. Moody</u>				22b. DATE SIGNED <u>5/28/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Edson B. Moody M.D.</u>	
22d. ADDRESS <u>145 S. Prospect St. Hagerstown, Md.</u>		22e. REC'D BY REGISTRAR <u>Charles Judge</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/29/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR <u>Rest Haven Funeral Chapel</u>				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MAY 31 1966

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Reg. Dist. No. 07561

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>183 Berkson Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wallace Reed Brooks Jr.</u>		4. DATE OF DEATH Month Day Year <u>May 13 1966</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1966</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>Wallace Reed Brooks Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Lorraine Christian</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7625 Asphyxia of Newborn</u> DUE TO (b) <u>Prematurity (born home)</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/11</u> , 19 <u>66</u> , to <u>5/12</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>5/11/66</u> , at <u>12</u> M., and that death occurred at <u>2:34</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard A. Young</u>		M.D. <u>101 King Street Hagerstown Md.</u>	
PHYSICIAN'S NAME (Type) <u>Richard A. Young</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-21-1966</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R Watson Jr Hagerstown Md.</u>		ADDRESS <u>101 King Street Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>MAY 23 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07572

07562

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b> c. LENGTH OF STAY IN 1b <b>Life time</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b> d. STREET ADDRESS <b>136 William Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Gertrude</b> Middle <b>Alice</b> Last <b>Burnett</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1966</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 15, 1929</b>	9. AGE (In years last birthday) <b>36</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>			
13. FATHER'S NAME <b>Alex Burn</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME <b>Louise Pulpes</b>		
15. INFIRMANT <b>George Burnett</b>				Address <b>136 William Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>6000</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>flare-up of chronic pyelonephritis</b> DUE TO <b>alcoholism</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>???</b>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Howard N. Weeks</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		5/13/66 22. DATE SIGNED			
EXAMINER'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>580 Northern Ave. Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/13/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Hagerstown, Maryland</b>				
24. FUNERAL DIRECTOR <b>John R Watson of Hagerstown Md.</b>		ADDRESS		25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1978

09202

MEMORANDUM FOR THE DIRECTOR

TO : DIRECTOR, FBI

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07573

CERTIFICATE OF DEATH

07563

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>		c. LENGTH OF STAY IN lb <b>5 Yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>109 Williams Circle</b>		d. STREET ADDRESS <b>109 Williams Circle</b>	
3. NAME OF DECEASED (Type or print) <b>LAURA BALNCHE BYERS</b>		4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 23 1878</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Jefferson Co. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William H. Byers</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Malloy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-40-7022</b>	
17. INFORMANT <b>Mrs Ruth Ristle</b>		Address <b>109 Williams Circle</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma - Stomach</b> DUE TO (b) <b>Hypertensive vascular Disease</b> DUE TO (c) <b>151 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs.</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <b>3/5</b> , 19 <b>55</b> , to <b>5/25</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/25</b> , 19 <b>66</b> , and that death occurred at <b>2:58 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Philip J. Hirshman</b>		22b. DATE SIGNED <b>5/26/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		22d. ADDRESS <b>159 W. Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/28/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Elmwood Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Shepherdstown W. Va.</b>	
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc</b>		25a. RECEIVED BY REGISTRAR <b>MAY 31 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1958

CERTIFICATE OF DEATH

1958

MAY 11 1958

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>327 Barnett Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>EUGENE</u> Last <u>CLARK</u>		4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/5/1950</u>
9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Waynesboro, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wilbur R. Clark</u>		14. MOTHER'S MAIDEN NAME <u>Inez Cool</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>161-40-1444</u>	
17. INFORMANT <u>Wilbur R. Clark, 327 Barnett Ave, Waynesboro,</u>		Address <u>Penna.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> DUE TO (b) <u>HEAD INJURY-POSS. CEREBRAL CONTUSION &amp; ACUTE SUB-DURAL HEMATOMA. HEMOTHORAX. EX. MANDIBLE-CONTUSION OF BLADDER &amp; KIDNEYS</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <u>3 HRS.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>PINNED IN CAR THAT SWERVED FROM RD. STRIKING TREE</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6:30</u> a.m. <u>5/28/</u> 19 <u>66</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>ST. RT. 316</u>		20f. (City or town) (County) (State) <u>WAYNESBORO, PA. FRANKLIN</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dr. E. W. Ditto</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DR. E. W. DITTO, JR.</u>		22. DATE SIGNED <u>5/29/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 1, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Waynesboro Penna.</u>	
24. FUNERAL DIRECTOR <u>S. Martin Roe</u>		ADDRESS <u>Waynesboro, Penna.</u>	
25a. REC'D BY REGISTRAR <u>JUN 2 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

SHOCK

HEAD INJURY-POST-CEREBRAL CONTUSION &  
ACUTE SUB-DURAL HEMATOMA, HEMIPARESIS  
FX. MANDIBLE-CONTUSION OF BLADDER & KIDNEYS

PINNED IN CARTRIDGE SWEEPER FROM RO. STRIKING TREE

6:30 5/28/68 66 X ST. RT. 316 WAYNESBORO, P. FR. ILLIN

X

X

X

DR. E. W. DITT, JR.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
07575  
CERTIFICATE OF DEATH  
07565

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>50 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>531 N. Mulberry St.</u>				d. STREET ADDRESS <u>531 N. Mulberry St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Oliver</u> Last <u>Condon</u>				4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 31, 1901</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Parts</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Adams Co. Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Condon</u>				14. MOTHER'S MAIDEN NAME <u>Nora Sease</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-30-9029</u>		17. INFORMANT <u>Mrs. R.O. Condon</u>	
Address <u>Hagerstown, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Arteriosclerotic Cardiac Dis.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>12 yrs</u> <u>2-1 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Leg off for circulatory trouble.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>27 Oct</u> , 19 <u>65</u> , to <u>15 May</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>15 May</u> , 19 <u>66</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard T. Binford</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>16 May 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD, M. D.</u>				22d. ADDRESS <u>1135 POTOMAC AVENUE HAG. MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/18/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown</u> <u>MD</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u> <u>Rest Haven Funeral Chapel</u>				25. REC'D BY REGISTRAR <u>MAY 19 1966</u> DATE			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>5 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				21-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>						d. STREET ADDRESS <b>24 HIGH STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELLA</b>			First <b>MAE</b>			Middle <b>CORNELL</b>			Last <b>MAY</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 13, 1895</b>		9. AGE (In years last birthday) <b>70</b> yrs.		10. FINDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FRANKLIN CO., PENNA.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH TOSTON</b>						14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>215-20-9520</b>		17. INFORMANT <b>HAGERSTOWN, MARYLAND</b> <b>MRS. MABEL SHIPLEY 1428 SALEM AVE.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung Abscesses Rt Lung.</b> <b>5272</b> DUE TO (b) <b>Capillary Necrosis of Lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia</b> <b>Cardiomegaly</b>										INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>unknown</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>7-30</b> , 19 <b>66</b> , to <b>5-5</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-5-66</b> , 19 <b>66</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>E.R. Lardizabal M.D.</b>						22b. DATE SIGNED <b>5/6/1966</b>			22c. PHYSICIAN'S NAME (Type) <b>E.R. LARDIZABAL M.D.</b>		
22d. ADDRESS <b>2 NORTH AVE. HAGERSTOWN, MARYLAND</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>MAY 8, 1966</b>			23c. NAME OF CEMETERY OR CREMATORY <b>BAKERSVILLE CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>WASHINGTON CO. MARYLAND</b>		
24. FUNERAL DIRECTOR <b>Charles M. Rayer</b>						ADDRESS <b>HAGERSTOWN, MARYLAND</b>			25a. REC'D BY REGISTRAR <b>MAY 9 1966</b>		
									25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
07576					07566				
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>17 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1720 W. Washington St.</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b> d. STREET ADDRESS <b>1720 W. Washington St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Charles William Corwell</b>					4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 66</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 16, 1886</b>		9. AGE (in years last birthday) <b>79</b> yrs. <b>4</b> Months <b>21</b> Days <b>1</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Buchanan Valley, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles McClay Corwell</b>					14. MOTHER'S MAIDEN NAME <b>Annie Elizebeth Kane</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-38-2311</b>		17. INFORMANT <b>Mrs Anna B. Corwell</b>		Address <b>1720 W. Wash. St. Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis with right hemiplegia</b> <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b> (c) <b>Arteriosclerosis, generalized</b>								INTERVAL BETWEEN ONSET AND DEATH <b>one week</b> <b>unknown</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 30</b> <b>19 66</b> to <b>May 07</b> <b>19 66</b> , that (I) (we) last saw the deceased alive on <b>May 06</b> <b>19 66</b> , and that death occurred at <b>7:00 A</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Archie Robert Cohen</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>May 08, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.,</b>						22d. ADDRESS <b>Clear Spring, Maryland 21722</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/10/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Margaret Rowland</b>		ADDRESS <b>Clear Spring, Md.</b>		DATE <b>MAY 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>48 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Maryland State Hospital</u>				d. STREET ADDRESS <u>413 Mitchell Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard Monroe Crouse Sr.</u>				4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 11, 1914</u>		9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Produce</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dealer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co. Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Adam Crouse</u>				14. MOTHER'S MAIDEN NAME <u>Lelia Grace Rock</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-4141</u>		17. INFORMANT <u>Mrs. Meda Crouse</u>		Address <u>413 Mitchell Ave. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured esophageal varices</u> 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>cirrhosis of liver</u> DUE TO (c) <u>unknown</u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 19, 1966</u> , to <u>May 29, 1966</u> , that (I) (two) last saw the deceased alive on <u>May 29, 1966</u> , and that death occurred at <u>4:15 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Victor L. Ramos, M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>May 29, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS, MD</u>		22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/1/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Washington Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. O. Hunt</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR <u>MAY 31 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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7-24-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN lb <b>5 Yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>549 Frederick St.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>549 Frederick St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Floyd McClain Davis</b>		4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 14, 1894</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>8</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Downsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Cyrus Davis</b>		14. MOTHER'S MAIDEN NAME <b>Emiley Shipley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>220-18-0357</b>	
17. INFORMANT <b>Mrs. Lillie Davis</b>		18. ADDRESS <b>549 Frederick St. Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage due to Rupture of</b> DUE TO (b) <b>Aneurysm of R. Internal Iliac artery</b> DUE TO (c) <b>Arteriosclerotic Heart D. - Cerebral Arterio-sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
19. INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic Heart D. - Cerebral Arterio-sclerosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 17, 1966</b> , to <b>May 22, 1966</b> that (I) (we) last saw the deceased alive on <b>May 21, 1966</b> , and that death occurred at <b>6 A. M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Sidney Novenstein</b>		22b. DATE SIGNED <b>5-23-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN</b>		22d. ADDRESS <b>FUNKSTOWN MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5-25-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Benevola Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Benevola Wash. Co. Md.</b>
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 25 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07580					07570				
1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Western Maryland State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Poplar Springs</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Teresa</b> Middle <b>A.</b> Last <b>DeLauder</b>					4. DATE OF DEATH Month <b>5</b> Day <b>27</b> Year <b>1966</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/11/50</b>		9. AGE (In years last birthday) <b>85</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Poplar Springs, Md</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Andrew N. De Lauder</b>					14. MOTHER'S MAIDEN NAME <b>Margaret Kerr</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Edward De Lauder, Rt. 4 Mt. Airy, Md</b>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200 Acute Pulmonary Edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Thrombosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>Not known</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/5, 1964</b> to <b>5/27, 1966</b> , that (I) (we) last saw the deceased alive on <b>5/27, 1966</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Arturo R. Ilego</b>					M.O. ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>5-27-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTURO R. ILEGIO</b>					22d. ADDRESS <b>1500 Penn. Ave. Hagerstown, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-30-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Michaels</b>		23d. LOCATION (City, town or county) (State) <b>Poplar Springs, Md</b>			
24. FUNERAL DIRECTOR <b>F.C. Higinbotham, Elliott City, Md</b>						25a. REC'D BY REGISTRAR <b>MAY 31 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1280

Washington

Department

Western Railway State Hospital

June

Andrew S. De Lander

June

June

Andrew S. De Lander, No. 1 St. City, Md.

Andrew S. De Lander

Andrew S. De Lander, No. 1 St. City, Md.

Postel

7-10-1966

St. Michaels

Postel, Andrew S. De Lander, No. 1 St. City, Md.



TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

70

VR A15 (4)  
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07581

07571

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 3 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Friendship Manor Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 38 Glenside Avenue d. STREET ADDRESS Hagerstown, Maryland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last PATRICK HENRY DIFFENDALL		4. DATE OF DEATH Month Day Year May 10, 1966				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1878	9. AGE (In years last birthday) 87 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Man		10b. KIND OF BUSINESS OR INDUSTRY W. Md. Railroad		11. BIRTHPLACE (County & State, or foreign country) Westminister, Carroll Co, Md U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Peter Diffendall		14. MOTHER'S MAIDEN NAME Frances Warfield				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 214-09-0794		17. INFORMANT Address Mrs. Margaret Young 376 E. Wash. St, Hagerstown, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive CV Disease 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 yrs						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from May 15, 1966 to May 10, 1966 that (I) (we) last saw the deceased alive on May 10, 1966, and that death occurred at 4:55 P.M. from the causes and on the date stated above.						
22a. SIGNATURE Robert P. Conrad, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-11-66		
22c. PHYSICIAN'S NAME (Type) Robert P. Conrad		22d. ADDRESS 137 W. Washington Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/13/66	23c. NAME OF CEMETERY OR CREMATORY Corpus Christi Cemetery		23d. LOCATION (City, town or county) (State) Chambersburg, Franklin Co, Pa.		
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown, Maryland		25a. REC'D BY REGISTRAR MAY 16 1966 25b. REGISTRAR'S SIGNATURE Charles Judge		

800

MAY 10 1965  
Fleming, George

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07582

## CERTIFICATE OF DEATH

07572

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Route 6</u>			c. LENGTH OF STAY IN lb <u>3 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown, Route 6</u> <u>21-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1101 Maugans Avenue</u>				d. STREET ADDRESS <u>1101 Maugans Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUTH</u> <u>REBECCA</u> <u>DRAPER</u>				4. DATE OF DEATH Month Day Year <u>May</u> <u>30</u> , <u>19</u> <u>66</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 30, 1889</u> <u>77</u> yrs.	
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ft. Loudon, FRANKLIN Co., Pa.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Keyser</u>				14. MOTHER'S MAIDEN NAME <u>Mary Heinbaugh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Lester B. Draper 1101 Maugans Avenue,</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion -</u> <u>4201</u> DUE TO (b) <u>Arteriosclerotic heart Disease +</u> DUE TO (c) <u>general arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Large varicose ulcers - legs -</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 19</u> , 19 <u>65</u> , to <u>May 30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 18</u> , 19 <u>66</u> , and that death occurred at <u>6:00</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Edward W. Ditto III</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/31/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u>				22d. ADDRESS <u>217 W. Washington St. Hag., Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/1/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Wash. Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman Funeral Home, Inc.</u>				25a. REC'D BY REGISTRAR <u>JUN 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

17505

CONTINUATION OF DATA

RECEIVED IN THE OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C. 20315

1. NAME OF THE PROJECT		2. NAME OF THE INVESTIGATOR	
3. TITLE OF THE PROJECT		4. SUMMARY OF THE PROJECT	
5. STATEMENT OF WORK		6. STATEMENT OF RESULTS	
7. STATEMENT OF CONCLUSIONS		8. STATEMENT OF RECOMMENDATIONS	
9. STATEMENT OF FUTURE WORK		10. STATEMENT OF REFERENCES	
11. STATEMENT OF ACKNOWLEDGMENTS		12. STATEMENT OF DISTRIBUTION	
13. STATEMENT OF OTHER INFORMATION		14. STATEMENT OF SIGNATURE	
15. STATEMENT OF DATE		16. STATEMENT OF LOCATION	

JUN 3 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

07583

CERTIFICATE OF DEATH

07573

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 15 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 31 W. Franklin Street		d. STREET ADDRESS 31 W. Franklin Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WALTER SAMUEL FAHRNEY		4. DATE OF DEATH Month Day Year May 28, 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1877
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) St. James, Wash. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Fahrney		14. MOTHER'S MAIDEN NAME Mary Elizabeth Middlekauff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 314-09-8985	
17. INFORMANT Miss Phyllis Fahrney		Address 31 W. Franklin St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr 10 gm	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1965, to May 28, 1966, that (I) (we) last saw the deceased alive on May 28, 1966, and that death occurred at 100 M, from causes and on the date stated above.			
22a. SIGNATURE J H Beccia Jr		22b. DATE SIGNED May 28 1966	
22c. PHYSICIAN'S NAME (Type) J H Beccia Jr		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/31/66	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or town) (County) (State) Hag. Wash. Co., Md.	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home, Inc. Hagerstown, Maryland		25a. REC'D BY REGISTRAR JUN 3 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 07574

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Harrisville</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>15 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fetterhoff, Bessie Mae</u>		4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 15, 1924</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HARRISONVILLE</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph E Lowery</u>		14. MOTHER'S MAIDEN NAME <u>Bernice Strait</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>174-20-4477</u>	
17. INFORMANT <u>John H. Fetterhoff</u>		Address <u>Harrisville Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Irrversible shock, 3</u> <u>578X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute gastrointestinal hemorrhages</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> <u>36 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterioclerotic heart disease; metastatic carcinoma, liver</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>  19  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 16</u> , 19 <u>66</u> , to <u>May 17</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>May 16</u> , 19 <u>66</u> , and that death occurred at <u>8:10A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1229 Ravenwood Hgts., Hagerstown, Md</u> DATE SIGNED <u>5/18/66</u>			
ACTUAL SIGNATURE <u>John H. Kehne</u>		PHYSICIAN'S NAME (Type) <u>John H. Kehne, M. D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial May 20 1966</u>		22b. DATE THEREOF <u>May 20 1966</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sidling Hill Christian Reformed Church</u>		22d. LOCATION (City, town, or county) (State) <u>Needmore, Fulton Co Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Judge</u>		ADDRESS <u>Harrisville Pa</u>	
24a. REC'D BY REGISTRAR <u>May 20 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

FILED  
JAN 24  
B O M E

*John H. Stetson*

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07585

## CERTIFICATE OF DEATH

07575

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>10 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington county Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 21-1 d. STREET ADDRESS <u>1323 W. Church Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>MARGARET VIRGINIA FIZER</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>May 24, 19 66</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 8, 1911</u>		<b>9. AGE</b> (In years lost birthday) yrs. <u>55</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired.) <u>Machine Operator</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Dorbee Mfg. Co.</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Duckfield, W. Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>Edward Franklin Cornell</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Josephene Brown</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>			<b>16. SOCIAL SECURITY NO.</b> <u>219-12-1232</u>		<b>17. INFORMANT</b> Address <u>Sheridan Fizer 1323 W. Church St.</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema = cerebellar compression</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hemorrhage from rupture aneurysm</u> DUE TO <u>10 days</u> (c) <u>st. Middle cerebral artery</u>								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 days</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>May 15</u>, 19<u>66</u>, to <u>May 24</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>May 24</u>, 19<u>66</u>, and that death occurred at <u>11:42</u> M, from causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>Edward W. Ditto, III</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						<b>22b. DATE SIGNED</b> <u>5-25-66</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Edward W. Ditto, III, M.D.</u>				<b>22d. ADDRESS</b> <u>217 W. Washington St., Hagerstown, Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>5/27/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lutheran Cemetery</u>		<b>23d. LOCATION (City or Town) (County) (State)</b> <u>Bakersville, Wash. Co. Md.</u>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Andrew K. Coffman Funeral Home, Inc.</u> <u>Hagerstown, Maryland</u>				<b>25a. REC'D BY REGISTRAR</b> <u>MAY 31 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

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CONTINUED ON OTHER

1. NAME OF VESSEL		2. TYPE OF VESSEL		3. HOME PORT	
4. DATE OF DEPARTURE		5. TIME OF DEPARTURE		6. DESTINATION	
7. NAME OF CAPTAIN		8. NAME OF MASTER		9. NAME OF FIRST OFFICER	
10. NAME OF SECOND OFFICER		11. NAME OF THIRD OFFICER		12. NAME OF FOURTH OFFICER	
13. NAME OF FIFTH OFFICER		14. NAME OF SIXTH OFFICER		15. NAME OF SEVENTH OFFICER	
16. NAME OF EIGHTH OFFICER		17. NAME OF NINTH OFFICER		18. NAME OF TENTH OFFICER	
19. NAME OF ELEVENTH OFFICER		20. NAME OF TWELFTH OFFICER		21. NAME OF THIRTEENTH OFFICER	
22. NAME OF FOURTEENTH OFFICER		23. NAME OF FIFTEENTH OFFICER		24. NAME OF SIXTEENTH OFFICER	
25. NAME OF SEVENTEENTH OFFICER		26. NAME OF EIGHTEENTH OFFICER		27. NAME OF NINETEENTH OFFICER	
28. NAME OF TWENTIETH OFFICER		29. NAME OF TWENTY-FIRST OFFICER		30. NAME OF TWENTY-SECOND OFFICER	
31. NAME OF TWENTY-THIRD OFFICER		32. NAME OF TWENTY-FOURTH OFFICER		33. NAME OF TWENTY-FIFTH OFFICER	
34. NAME OF TWENTY-SIXTH OFFICER		35. NAME OF TWENTY-SEVENTH OFFICER		36. NAME OF TWENTY-EIGHTH OFFICER	
37. NAME OF TWENTY-NINTH OFFICER		38. NAME OF THIRTIETH OFFICER		39. NAME OF THIRTY-FIRST OFFICER	
40. NAME OF THIRTY-SECOND OFFICER		41. NAME OF THIRTY-THIRD OFFICER		42. NAME OF THIRTY-FOURTH OFFICER	
43. NAME OF THIRTY-FIFTH OFFICER		44. NAME OF THIRTY-SIXTH OFFICER		45. NAME OF THIRTY-SEVENTH OFFICER	
46. NAME OF THIRTY-EIGHTH OFFICER		47. NAME OF THIRTY-NINTH OFFICER		48. NAME OF FORTY OFFICER	
49. NAME OF FORTY-FIRST OFFICER		50. NAME OF FORTY-SECOND OFFICER		51. NAME OF FORTY-THIRD OFFICER	
52. NAME OF FORTY-FOURTH OFFICER		53. NAME OF FORTY-FIFTH OFFICER		54. NAME OF FORTY-SIXTH OFFICER	
55. NAME OF FORTY-SEVENTH OFFICER		56. NAME OF FORTY-EIGHTH OFFICER		57. NAME OF FORTY-NINTH OFFICER	
58. NAME OF FIFTY OFFICER		59. NAME OF FIFTY-FIRST OFFICER		60. NAME OF FIFTY-SECOND OFFICER	
61. NAME OF FIFTY-THIRD OFFICER		62. NAME OF FIFTY-FOURTH OFFICER		63. NAME OF FIFTY-FIFTH OFFICER	
64. NAME OF FIFTY-SIXTH OFFICER		65. NAME OF FIFTY-SEVENTH OFFICER		66. NAME OF FIFTY-EIGHTH OFFICER	
67. NAME OF FIFTY-NINTH OFFICER		68. NAME OF SIXTY OFFICER		69. NAME OF SIXTY-FIRST OFFICER	
70. NAME OF SIXTY-SECOND OFFICER		71. NAME OF SIXTY-THIRD OFFICER		72. NAME OF SIXTY-FOURTH OFFICER	
73. NAME OF SIXTY-FIFTH OFFICER		74. NAME OF SIXTY-SIXTH OFFICER		75. NAME OF SIXTY-SEVENTH OFFICER	
76. NAME OF SIXTY-EIGHTH OFFICER		77. NAME OF SIXTY-NINTH OFFICER		78. NAME OF SEVENTY OFFICER	
79. NAME OF SEVENTY-FIRST OFFICER		80. NAME OF SEVENTY-SECOND OFFICER		81. NAME OF SEVENTY-THIRD OFFICER	
82. NAME OF SEVENTY-FOURTH OFFICER		83. NAME OF SEVENTY-FIFTH OFFICER		84. NAME OF SEVENTY-SIXTH OFFICER	
85. NAME OF SEVENTY-SEVENTH OFFICER		86. NAME OF SEVENTY-EIGHTH OFFICER		87. NAME OF SEVENTY-NINTH OFFICER	
88. NAME OF EIGHTY OFFICER		89. NAME OF EIGHTY-FIRST OFFICER		90. NAME OF EIGHTY-SECOND OFFICER	
91. NAME OF EIGHTY-THIRD OFFICER		92. NAME OF EIGHTY-FOURTH OFFICER		93. NAME OF EIGHTY-FIFTH OFFICER	
94. NAME OF EIGHTY-SIXTH OFFICER		95. NAME OF EIGHTY-SEVENTH OFFICER		96. NAME OF EIGHTY-EIGHTH OFFICER	
97. NAME OF EIGHTY-NINTH OFFICER		98. NAME OF NINETY OFFICER		99. NAME OF NINETY-FIRST OFFICER	
100. NAME OF NINETY-SECOND OFFICER		101. NAME OF NINETY-THIRD OFFICER		102. NAME OF NINETY-FOURTH OFFICER	
103. NAME OF NINETY-FIFTH OFFICER		104. NAME OF NINETY-SIXTH OFFICER		105. NAME OF NINETY-SEVENTH OFFICER	
106. NAME OF NINETY-EIGHTH OFFICER		107. NAME OF NINETY-NINTH OFFICER		108. NAME OF HUNDRED OFFICER	
109. NAME OF HUNDRED-FIRST OFFICER		110. NAME OF HUNDRED-SECOND OFFICER		111. NAME OF HUNDRED-THIRD OFFICER	
112. NAME OF HUNDRED-FOURTH OFFICER		113. NAME OF HUNDRED-FIFTH OFFICER		114. NAME OF HUNDRED-SIXTH OFFICER	
115. NAME OF HUNDRED-SEVENTH OFFICER		116. NAME OF HUNDRED-EIGHTH OFFICER		117. NAME OF HUNDRED-NINTH OFFICER	
118. NAME OF HUNDRED-TENTH OFFICER		119. NAME OF HUNDRED-ELEVENTH OFFICER		120. NAME OF HUNDRED-TWENTY OFFICER	
121. NAME OF HUNDRED-TWENTY-ONE OFFICER		122. NAME OF HUNDRED-TWENTY-TWO OFFICER		123. NAME OF HUNDRED-TWENTY-THREE OFFICER	
124. NAME OF HUNDRED-TWENTY-FOUR OFFICER		125. NAME OF HUNDRED-TWENTY-FIVE OFFICER		126. NAME OF HUNDRED-TWENTY-SIX OFFICER	
127. NAME OF HUNDRED-TWENTY-SEVEN OFFICER		128. NAME OF HUNDRED-TWENTY-EIGHT OFFICER		129. NAME OF HUNDRED-TWENTY-NINE OFFICER	
130. NAME OF HUNDRED-THIRTY OFFICER		131. NAME OF HUNDRED-THIRTY-ONE OFFICER		132. NAME OF HUNDRED-THIRTY-TWO OFFICER	
133. NAME OF HUNDRED-THIRTY-THREE OFFICER		134. NAME OF HUNDRED-THIRTY-FOUR OFFICER		135. NAME OF HUNDRED-THIRTY-FIVE OFFICER	
136. NAME OF HUNDRED-THIRTY-SIX OFFICER		137. NAME OF HUNDRED-THIRTY-SEVEN OFFICER		138. NAME OF HUNDRED-THIRTY-EIGHT OFFICER	
139. NAME OF HUNDRED-THIRTY-NINE OFFICER		140. NAME OF HUNDRED-FORTY OFFICER		141. NAME OF HUNDRED-FORTY-ONE OFFICER	
142. NAME OF HUNDRED-FORTY-TWO OFFICER		143. NAME OF HUNDRED-FORTY-THREE OFFICER		144. NAME OF HUNDRED-FORTY-FOUR OFFICER	
145. NAME OF HUNDRED-FORTY-FIVE OFFICER		146. NAME OF HUNDRED-FORTY-SIX OFFICER		147. NAME OF HUNDRED-FORTY-SEVEN OFFICER	
148. NAME OF HUNDRED-FORTY-EIGHT OFFICER		149. NAME OF HUNDRED-FORTY-NINE OFFICER		150. NAME OF FIFTY	

MAY 31 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07586						07576					
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>25 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1105 Beechwood Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Sterling</u> Middle <u>Roy</u> Last <u>Flanagan</u>			4. DATE OF DEATH Month <u>May</u> Day <u>10</u> Year <u>19 66</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 8, 1899</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Metal Heat Treating</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Sterling Price Flanagan</u>						14. MOTHER'S MAIDEN NAME <u>Emma Wyatt</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>705-10-7074</u>		17. INFORMANT <u>Mrs. Erma F. Flanagan</u>			Address <u>Hagerstown, Md. 1105 Beechwood Dr.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary artery disease</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of liver; Pulmonary emphysema</u>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>none</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>none</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 13 '63</u> , 19 <u>  </u> , to <u>May 10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 9 '66</u> 19 <u>66</u> , and that death occurred at <u>PM</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Harold R. Tritch Jr</u>										22b. DATE SIGNED <u>5-11-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Harold R. Tritch, Jr</u>						22d. ADDRESS <u>302 N. Potomac St Hagerstown, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>5/13/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Hagerstown MD</u>			
24. FUNERAL DIRECTOR <u>Wm. A. Novak</u> <u>Rest Haven Funeral Chapel</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant, Maryland</u> d. STREET ADDRESS <u>403- 64th Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Alexander</u> Last <u>Fowler</u>			4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1966</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Feb. 23, 1874</u>			9. AGE (In years last birthday) <u>90</u> yrs.			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Wash. Railroad Electric Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>					
13. FATHER'S NAME <u>Unknown</u>						14. MOTHER'S MAIDEN NAME <u>Unknown</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs. Mae Roberts, 2051- 26th Street S.E. Washington, DC.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Heart Disease.</u> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>arteriosclerosis, general</u> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Old cerebral thrombosis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>October 4, 1965</u> to <u>May 17, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 17, 1966</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Victor L. Ramos, M.D.</u>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED <u>May 17, 1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>Victor L. Ramos, M.D.</u>						22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 20-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>					
24. FUNERAL DIRECTOR <u>Simmons Bros</u> ADDRESS <u>Simmons Bros. 1661- Gd. Hope Rd. SE. Wash., DC</u>						25a. REC'D BY REGISTRAR <u>MAY 20 1966</u>			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				

May 17, 1964

Feb. 21, 1964

John Alexander Fowler

Commissioner, State Bureau  
of Corrections, General

Collected materials

May 17, 1964

State of Kansas,  
Wesley C. Rame, M.D.

Received by  
Wesley C. Rame, M.D.  
May 17, 1964

MAY 18 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07588						07578					
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Hagerstown RFD 2				c. LENGTH OF STAY IN 1b 26 yrs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Hagerstown RFD #2 21-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Nursery Road						d. STREET ADDRESS Nursery Road					
3. NAME OF DECEASED (Type or print) First Middle Last William Henry Frey						4. DATE OF DEATH Month Day Year May 15 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1878		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY W. Md. R. R.		11. BIRTHPLACE (County & State, or foreign country) Chambersburg Pa.			12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME John Frey						14. MOTHER'S MAIDEN NAME Mary Burkholder					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 232 01 8910		17. INFORMANT Nursery Address Mrs. Pearl Frey Hagerstown Md. RFD 2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Arterio-sclerotic Heart Disease (b) Cerebral thrombosis due to (c) Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from May 5, 1966 to May 15, 1966, that (I) (we) last saw the deceased alive on May 15, 1966, and that death occurred at 4:00 PM, from the causes and on the date stated above.											
22a. SIGNATURE Sidney Novenstein						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-16-66			
22c. PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN						22d. ADDRESS FUNKSTOWN MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 18-66		23c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery			23d. LOCATION (City, town or county) (State) Chambersburg Pa.			
24. FUNERAL DIRECTOR Jennie E. Leaf Williamsport, Md.						25a. REC'D BY REGISTRAR MAY 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

1957

STATE OF TEXAS  
COUNTY OF DALLAS



John J. [illegible]  
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[illegible]

John J. [illegible]  
[illegible]  
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MAY 18 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07589 09041											
1. PLACE OF DEATH a. CDUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. CDUNTY Washington					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Smithsburg 21/1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lloyd Luther Gardenhour			4. DATE OF DEATH Month Day Year May 30 1966								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/12/1909		9. AGE (in years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner, Liquor Store				10b. KIND OF BUSINESS OR INDUSTRY Liquor Store		11. BIRTHPLACE (County & State, or foreign country) Waynesboro Pa.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Luther Gardenhour						14. MOTHER'S MAIDEN NAME Susan Stouffer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 173-03-3448		17. INFORMANT Mrs. Lloyd Gardenhour, Smithsburg Md., #3				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 15 minutes	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <del>the hospital</del> attended the deceased from 9:55 P.M. to 10:10 P.M. 5/30/66, that (I) <del>we</del> saw the deceased <del>in the hospital</del> above time, and that death occurred at 10:10 P.M. M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Dr. R. Amarillo</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/3/66	
22c. PHYSICIAN'S NAME (Type) Dr. R. Amarillo						22d. ADDRESS 120 W. Main St; Sharpsburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/2/66		23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City, town or county) (State) Waynesboro, Franklin Co. Pa.					
24. FUNERAL DIRECTOR <i>Walter Z. Grove</i>						ADDRESS Waynesboro Pa.		25a. REC'D BY REGISTRAR JUN 8 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-62

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07590											
07579											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 16 Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital						d. STREET ADDRESS 13 North Main					
3. NAME OF DECEASED (Type or print) First Middle Last George Henry Gardner						4. DATE OF DEATH Month Day Year May 15 1966					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Jan. 5 1894		9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reas. & Tavern				10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (County & State, or foreign country) Smithsburg Md.				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George V Gardner						14. MOTHER'S MAIDEN NAME Emma Florence Reynolds					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. 214-34-0952		17. INFORMANT Luther L Gardner Smithsburg md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured abdominal aortic aneurysm 451X DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic cardiovascular disease (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Marked rheumatoid arthritis, generalized. INTERVAL BETWEEN ONSET AND DEATH 6 mo. 10 yrs.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 12-18 1955, to 5-15 1966, that (I) (we) last saw the deceased alive on 5-15 1966, and that death occurred at 5 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Charles F. Hess M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5-16-66			
22c. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.						22d. ADDRESS Smithsburg, Maryland 21783					
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF May 17 1966		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Mausoleum		23d. LOCATION (City, town or county) Smithsburg		(State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home						ADDRESS Smithsburg Md.		25a. REC'D BY REGISTRAR MAY 18 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge	

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Washington County Hospital

North Main

George

Henry

University

May

100

Male

White

Age

Jan. 2, 1900

72

George V. Gardner

Owner

Washington Co.

George V. Gardner

St. George's Hospital

No.

27-1-100

George V. Gardner

George V. Gardner

George V. Gardner

George V. Gardner

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George V. Gardner

Washington Co.

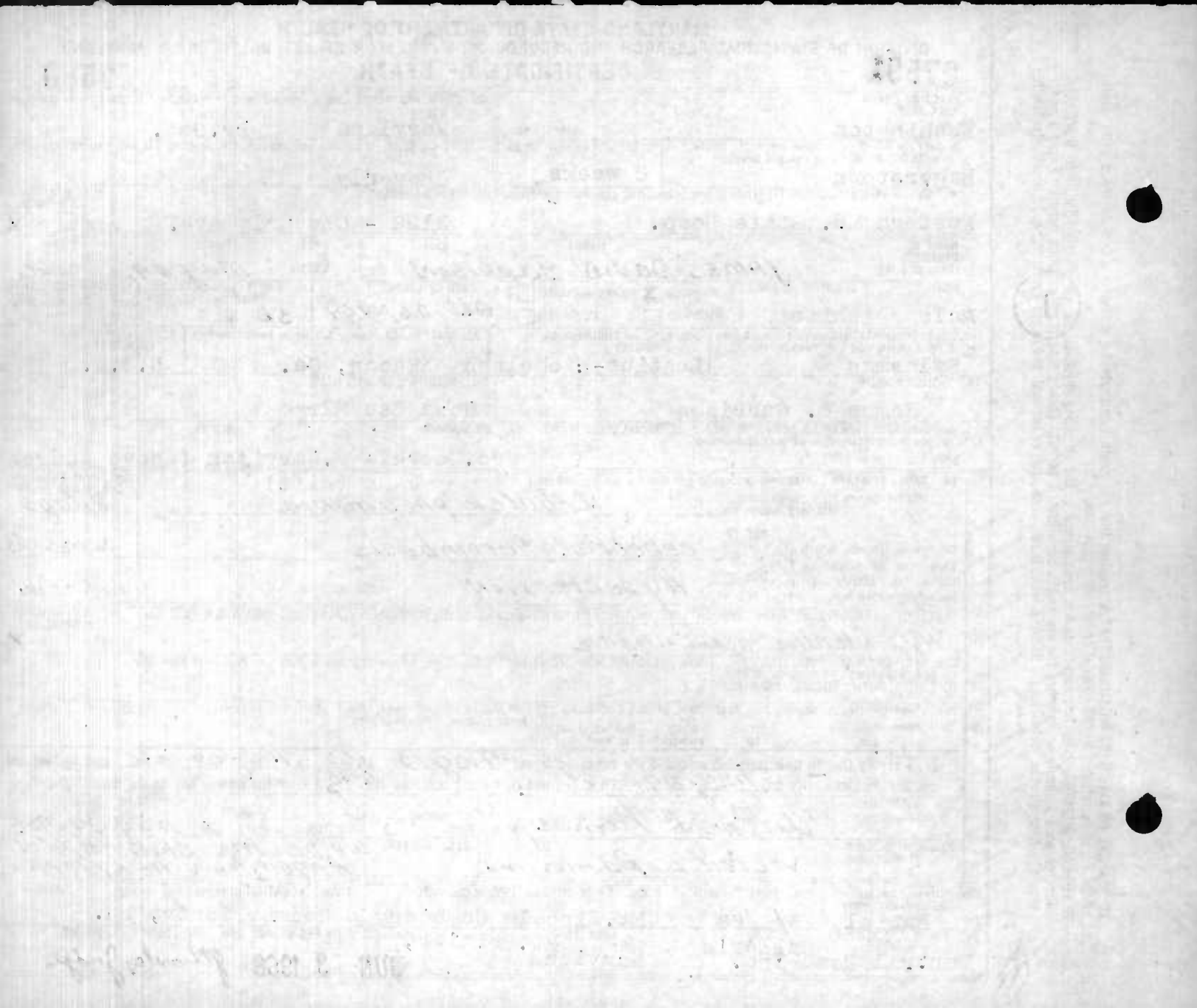
MAY 18 1900

George V. Gardner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND						
07592			07580			
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>3 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Md. State Hosp.</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> d. STREET ADDRESS <u>3122 - Cheverly Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JAMES DAVID GARRISON</u>			4. DATE OF DEATH Month Day Year <u>May 29, 1966</u>			
5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Oct. 26, 1909</u>			
9. AGE (In years, last birthday) <u>56</u> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Lustine-Nicholson</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Macon, Ga.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James D. Garrison</u>			14. MOTHER'S MAIDEN NAME <u>Rosa Lee Elrod</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>(If yes give war or dates of service)</u>			
17. INFORMANT <u>Mrs. Georgia E. Garrison (above address)</u>			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular pneumonia</u> (Wife) 332X DUE TO <u>cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive heart disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 12, 1966</u> , to <u>May 29, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 29, 1966</u> , and that death occurred at <u>6:40</u> P.M. from the causes and on the date stated above.						
22a. SIGNATURE <u>Victor L. Ramos, M.D.</u>			22b. DATE SIGNED <u>May 29, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS, M.D.</u>			22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>6/1/66</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md.</u>			
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>			25a. REC'D BY REGISTRAR <u>JUN 3 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>FRANKLIN</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>1 WEEK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHAMBERSBURG</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>					d. STREET ADDRESS <b>260 LINCOLN WAY WEST</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LEONA</b> Middle <b>KATHERINE</b> Last <b>GELSINGER</b>					4. DATE OF DEATH Month <b>MAY</b> Day <b>21</b> Year <b>19 66</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 18, 1914</b>		9. AGE (In years last birthday) <b>51</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FRANKLIN CO., PENNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARVEY BARNES</b>					14. MOTHER'S MAIDEN NAME <b>ANNIE CHRISTMAN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>CHAMBERSBURG, PENNA.</b> <b>CLAIR GELSINGER 260 LINCOLN WAY WEST</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive cerebral hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe hypertension</b> DUE TO (c) <b>Possibly Pheochromocytoma</b>								INTERVAL BETWEEN ONSET AND DEATH <b>11 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE <b>John J. Donoghue</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/23/1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>JOHN J DONOGHUE M.D.</b>					22d. ADDRESS <b>580 NORTHERN AVE. HAGERSTOWN, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>MAY 24, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. THOMAS CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>FRANKLIN CO., PENNA.</b>		
24. FUNERAL DIRECTOR <b>Charles M. Lougher</b>					ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>MAY 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



RECEIVED MAY 11 1966

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C. 20250

TO: DIRECTOR, AGRICULTURAL RESEARCH SERVICE

FROM: ASSISTANT SECRETARY FOR AGRICULTURAL RESEARCH

SUBJECT: AGRICULTURAL RESEARCH SERVICE

RE: AGRICULTURAL RESEARCH SERVICE

DATE: MAY 11 1966

BY: ASSISTANT SECRETARY FOR AGRICULTURAL RESEARCH

FOR THE DIRECTOR, AGRICULTURAL RESEARCH SERVICE

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C. 20250

TO: DIRECTOR, AGRICULTURAL RESEARCH SERVICE

FROM: ASSISTANT SECRETARY FOR AGRICULTURAL RESEARCH

SUBJECT: AGRICULTURAL RESEARCH SERVICE

RE: AGRICULTURAL RESEARCH SERVICE

DATE: MAY 11 1966

BY: ASSISTANT SECRETARY FOR AGRICULTURAL RESEARCH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>45 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>447 W. WASHINGTON ST.</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>447 W. WASHINGTON ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>MAYME</b> Middle <b>PEARL</b> Last <b>GILBERT</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>7</b> Year <b>19 66</b>			5. SEX <b>FEMALE</b>			6. COLOR OR RACE <b>WHITE</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>3/23/1890</b>			9. AGE (In years last birthday) <b>76 yrs.</b>			10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>		
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			11b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>			11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>WILLIAM KRINER</b>						14. MOTHER'S MAIDEN NAME <b>VENUS SLICK</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>219-14-8408</b>			17. INFORMANT <b>MR. NEVIN K. GILBERT</b>			Address <b>HANCASTER PA.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>4201</b> DUE TO <b>Advanced general arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>+ Atherosclerotic Heart Disease</b> (c) <b>+</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Immed.</b> <b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
21c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>			21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			21f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 28, 1965</b> to <b>May</b> , 1966, that (I) (we) last saw the deceased alive on <b>May 2</b> 1966, and that death occurred at <b>8:20</b> AM, from the causes and on the date stated above.											
22a. SIGNATURE <b>Edward W. Ditto III</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>5-9-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D.</b>						22d. ADDRESS <b>217 W. Wash. St. Hag., Md.</b>					
23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>5/10/66</b>			23c. NAME OF CEMETERY OR CREMATORY <b>LEITERSBURG LUTHERN</b>			23d. LOCATION (City, town or county) (State) <b>LEITERSBURG MD.</b>		
24. FUNERAL DIRECTOR <b>W. J. Norment, Hagerstown, Md.</b>						ADDRESS <b>Hagerstown, Md.</b>			25a. REC'D BY REGISTRAR <b>MAY 12 1966</b>		
									25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

1952

DEATH CASE OF DEATH

1952

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

447 W. WASHINGTON ST.

447 W. WASHINGTON ST.

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1-210-14-3-08 R. RIVER E. GILBERT

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WASHINGTON

MAY 1 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07594					07583				
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>50 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>919 OAK ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA MAE G. GROVE</b>			4. DATE OF DEATH Month Day Year <b>MAY 22 1966</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/12/1908</b>		9. AGE (In years last birthday) <b>58</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRACTICAL NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NURSING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>HARMON A. HOUSE</b>				14. MOTHER'S MAIDEN NAME <b>FLORENCE POWELL</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>219-05-2951</b>		17. INFORMANT <b>MR. MILTON L. KERSHNER</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolus</b> <b>4201</b> DUE TO <b>Mural auricular thrombi</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>due to Auricular fibrillation</b> DUE TO <b>episodic 1 year.</b> (c) <b>Atherosclerotic heart disease with coronary occlusion certain 1 yr.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>11 hours</b> <b>unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <del>this hospital</del> attended the deceased from <b>May 10</b> , 19 <b>66</b> , to <b>May 22</b> , 19 <b>66</b> , that (I) <del>we</del> last saw the deceased alive on <b>May 22</b> , 19 <b>66</b> , and that death occurred at <b>4:45 PM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>William T. Layman</b>				22b. DATE SIGNED <b>May 24, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>			
22d. ADDRESS <b>100 Professional Arts Bldg. Hagerstown, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/25/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BEST HAVEN CEM.</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MD.</b>			
24. FUNERAL DIRECTOR <b>W. J. Horment, Hagerstown, Md</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>MAY 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



07595

CERTIFICATE OF DEATH

07584

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown B #2 Sharpsburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>Route #1 Gateway Nursing Home</u>	
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>BORTZ</u> Last <u>HAFER</u>		4. DATE OF DEATH Month <u>May</u> Day <u>35</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 12 1892</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tavern Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Bedford Bedford Co Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick Hafer</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Gardner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-16-0320</u>	
17. INFORMANT <u>Mrs Pauline Hafer</u>		Address <u>318 Elizabeth Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u> DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Stomach</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u> ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic C-V Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>15 June</u> , 19 <u>63</u> , to <u>25 May</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>25 May</u> , 19 <u>66</u> , and that death occurred at <u>5:30 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W. H. Fender</u>		22b. DATE SIGNED <u>26 May 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. Fender</u>		22d. ADDRESS <u>216 N. Potomac St. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-28-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash Co Md</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR <u>MAY 31 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

52582

CERTIFICATE OF DEATH

52582

Name of Deceased		Date of Birth	
Sex		Race	
Marital Status		Occupation	
Cause of Death		Place of Death	
Time of Death		Signature of Physician	
Signature of Registrar		Signature of Coroner	
Date of Death		Date of Entry	

MAY 21 1968

William J. ...

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 05-21-1968 BY 1045 JMS/...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07596		07585	
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Greencastle, Pa.</u>	
c. LENGTH OF STAY IN 1b <u>3 Days</u>		d. STREET ADDRESS <u>RD #1 - Greencastle, Pa.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ivy</u> Middle <u>Sarah</u> Last <u>Hager</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/1/1882</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel F. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Kathryn Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>204-30-6982</u>	
17. INFORMANT <u>Bruce L. Hager</u>		Address <u>RD 1 - Greencastle, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac dilatation - acute</u> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Rheumatic heart disease</u> DUE TO (c) <u>50-60 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-30-66</u> 19, to <u>5-3-66</u> 19, that (I) (we) last saw the deceased alive on <u>5-3-66</u> 19, and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm. C. Brewer</u>		22b. DATE SIGNED <u>5-4-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. C. BREWER, M.D.</u>		22d. ADDRESS <u>Greencastle, Pa.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		23b. DATE THEREOF <u>5/6/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Browns Mill Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Kauffman Station, Pa.</u>	
24. FUNERAL DIRECTOR <u>A.E. Minnich - Greencastle, Pa.</u>		25a. REC'D BY REGISTRAR <u>MAY 6 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

222

222

MAY 1955

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a preliminary certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

99

MEDICAL CERTIFICATION

2

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07597

07586

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN ID <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>10225 Kensington Pkwy</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Kenneth</b> Middle <b>V.</b> Last <b>Harvey</b>				4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 12, 1908</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>7</b>		IF UNDER 24 HRS. Hours <b>19</b> Min. <b>66</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D C</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Richard K. Harvey</b>				14. MOTHER'S MAIDEN NAME <b>Elsie Mawrey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Gladys W. Harvey,</b> Address <b>See Blk #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b> <b>SEVERAL YRS.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>[Signature]</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>5-7-66</b>	
EXAMINER'S NAME (Type) <b>DR. E.W. DITTO, JR.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 10, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawlers Sons Inc.</b> ADDRESS <b>Wash. DC</b>				25a. REC'D BY REGISTRAR <b>DATE MAY 10 1966</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

INSTANT  
SEVERAL  
YRS.

ARTERIOSCLEROTIC HEART DISEASE  
CORONARY OCCLUSION

X

X

X

5-7-55

DR. E.W. DITTO, JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural, Waynesboro</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					d. STREET ADDRESS <u>75-3</u>				
3. NAME OF DECEASED (Type or print) First <u>Curvan</u> Middle <u>B.</u> Last <u>Heiges</u>					4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/5/1892</u>		9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Franklintown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Heiges</u>					14. MOTHER'S MAIDEN NAME <u>Ida Heiges</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes World War 1</u>				16. SOCIAL SECURITY NO. <u>163-07-7278</u>		17. INFORMANT <u>Mrs. Curvan Heiges, Waynesboro Pa., #3</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>4201</u> DUE TO (b) <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>0022 Arrested tuberculosis of lungs, probable hypoxemia</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I (this hospital) attended the deceased from <u>April 25, 1966</u> to <u>May 30, 1966</u> , that (we) last saw the deceased alive on <u>May 30, 1966</u> , and that death occurred at <u>2:20 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Joseph C. Crisp MD</u>								22b. DATE SIGNED <u>5-31-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH C. CRISP</u>								22d. ADDRESS <u>580 NORTHERN HAGERSTOWN MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/2/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		23d. LOCATION (City, town or county) (State) <u>Mercersburg Pa.</u>	
24. FUNERAL DIRECTOR <u>Walter J. Strove</u>				ADDRESS <u>Waynesboro Pa.</u>		25a. REC'D BY REGISTRAR <u>JUN 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07599		Item 9 Film G376 5/17/66 mh		07588	
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>5 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chambersburg</u> 75-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home wood Church Home</u>		d. STREET ADDRESS <u>39 west King</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>McCurdy</u> Last <u>Heintzelman</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1966</u>			
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 17, 1883</u> 8283 yrs.		9. AGE (In years lost birthday) <u>82</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Chambersburg, Pa</u>	
13. FATHER'S NAME <u>Benjamin F McCurdy</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>125-03-0382</u>		17. INFORMANT <u>Mark Wagner</u> Address <u>2750 Va Ave</u> <u>Wesport, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Hypertensive CV Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 15</u> 19 <u>65</u> to <u>May 7</u> 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>5-7</u> 19 <u>66</u> and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Robert P. Conrad</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-8-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>		22d. ADDRESS <u>Hagerstown, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/10/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove</u>	
23d. LOCATION (City, town, or county) <u>Chambersburg, Pa.</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Hager</u> ADDRESS <u>Hagerstown Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>John Judge</u>	

STATE OF TEXAS  
COUNTY OF DALLAS

FILE NO. 100-100000  
DATE 10-10-1910  
BY J. M. W. T. 100-100000  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
075800					07589				
1. PLACE OF DEATH a. COUNTY WASHINGTON					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 60 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL					d. STREET ADDRESS 32 E. WASHINGTON ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EVA Middle PAULINE Last HERBERT		4. DATE OF DEATH Month MAY Day 1 Year 66							
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/23/1900	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME JACOB FROCK				14. MOTHER'S MAIDEN NAME MINNIE EYLER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-42-7617		17. INFORMANT MRS. LAVALE SHAW		RT. #1 Address SHARPSBURG MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 <i>Acute Pulmonary Edema</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Anterior-superior Heart Disease</i> DUE TO (c) <i>BS</i>								INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>5 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Smallest Arterio</i>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>3/1</i> , 19 <i>63</i> , to <i>4/30</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>4/30</i> 19 <i>66</i> , and that death occurred at <i>7:30</i> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>Edson B. Moody</i>				22b. DATE SIGNED <i>5/3/66</i>					
22c. PHYSICIAN'S NAME (Type) Edson B. Moody, M. D.				22d. ADDRESS 145 S. Prospect St. Hagerstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/3/66		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City, town or county) (State) HAGERSTOWN MD.			
24. FUNERAL DIRECTOR <i>W. J. Norment</i>				ADDRESS <i>Hagerstown, Md.</i>		25a. REC'D BY REGISTRAR MAY 5 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07601					07590						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY			Washington		a. STATE			Maryland			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			Rural Smithsburg		b. COUNTY			Washington			
c. LENGTH OF STAY IN 1b			65 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			Smithsburg R. D. 3		d. STREET ADDRESS						
e. IS RESIDENCE ON A FARM?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
S. Allen Hess							May 10 1966				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Sept. 30, 1898		67 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Farmer								Franklin Co., Penna.			
12. CITIZEN OF WHAT COUNTRY?				U.S.A.							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
John W. Hess				Emma Rouzer							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address			
no				212-38-8793				Mrs. S. Allen Hess Smithsburg #3, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>										<u>Instant</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) <u>Arterio-sclerotic heart disease</u>										<u>15 yrs</u>	
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June, 1946</u> to <u>5-11, 1966</u> , that (I) <u>last</u> saw the deceased alive on <u>5-7-1966</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Walter H. Wishard</u>				M.D. PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-11-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Walter H. Wishard</u>				22d. ADDRESS <u>Waynesboro, Penna.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/13/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ringgold</u>		23d. LOCATION (City, town or county) (State) <u>Ringgold, Washington Co., Md.</u>			
24. FUNERAL DIRECTOR <u>Walter J. Gae</u>				ADDRESS <u>Waynesboro, Penna.</u>		25a. REC'D BY REGISTRAR <u>MAY 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

STATE OF OHIO

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IN SENATE

January 1, 1880

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1880

OF



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07602

## CERTIFICATE OF DEATH

07591

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>40 Years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>316 Frederick Street</u>		d. STREET ADDRESS <u>316 Frederick Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HAZEL</u> <u>ETHEL</u> <u>HOFFMAN</u>		4. DATE OF DEATH Month Day Year <u>May</u> <u>17</u> , 19 <u>66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1897</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Clearspring, Wash. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Hull</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Dennis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Grant L. Hoffman</u>		Address <u>316 Frederick Street</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Retinoblastoma Cell Sarcoma</u> DUE TO (b) <u>2000</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>arteriosclerotic Cardiac Des.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3 May, 1965</u> , to <u>16 May, 1966</u> , that (I) (we) last saw the deceased alive on <u>16 May, 1966</u> , and that death occurred at <u>5A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Richard T. Binford</u>		22b. DATE SIGNED <u>18 May 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD T. BINFORD, M. D.</u>		22d. ADDRESS <u>1135 POTOMAC AVENUE HAGERSTOWN, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 19, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery Hagerstown, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Andrew K. Coffman Hagerstown, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAY 23 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF TEXAS

1003

STATE OF TEXAS

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## CERTIFICATE OF DEATH

07592

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>1 week</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>54 North Cannon Ave</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ellis Guy Hoover</b>		4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan'y 19 1893</b>
9. AGE (In years - last birthday) <b>73 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Christian Hoover</b>		14. MOTHER'S MAIDEN NAME <b>Emma Winters</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-36-4869</b>	
17. INFORMANT <b>Mrs Mary C. Hoover</b>		Address <b>54 No Cannon Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>50 uremia due Benign nephrosclerosis</b> 260x DUE TO (b) <b>Chronic liver &amp; ascites</b> DUE TO (c) <b>Diabetes Mellitus, controlled</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>3 yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic vascular Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-12-54, 1954</b> , to <b>May 18, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 18, 1966</b> , and that death occurred at <b>11:45</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Edward W. Ditto III</b>		22b. DATE SIGNED <b>5-20-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D.</b>		22d. ADDRESS <b>217 West Washington Street Hag., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/21/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md</b>	
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Funeral Home Inc</b>		25a. REC'D BY REGISTRAR <b>MAY 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

07604

07593

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jackson Convalescent Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Myersville</u> 10-2 d. STREET ADDRESS <u>Route # 1</u> a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Mary</u> Middle <u>Virginia</u> Last <u>Hoover</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>9</u> Year <u>19 66</u>											
<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>February 5, 1876</u>		<b>9. AGE</b> (In years last birthday) <u>90</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington Co. Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Francis Valentine</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Barbara Ann Gaylor</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>none</u>				<b>17. INFORMANT</b> Address <u>Mrs. Gladys Blickenstaff, Myersville, Md.</u> Rt. # <u>1</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial ischemia</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arterio Sclerosis</u> DUE TO (c) <u>Arterio Sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>2 yrs</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>															
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Hour a.m. <u>  </u> p.m. <u>  </u>		<b>Month, Day, Year</b> <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>May 9 1966</u> to <u>May 9 1966</u> that (I) (we) last saw the deceased alive on <u>May 9 1966</u> and that death occurred <u>2:45 PM</u> from the causes and on the date stated above.															
<b>22a. SIGNATURE</b> <u>Her G. K. B. H. L. C. R.</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>May 10 1966</u>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Dr. G. C. Kohler</u>						<b>22d. ADDRESS</b> <u>Smithsburg Md</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>May, 12, 1966</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Marks Lutheran</u>				<b>23d. LOCATION</b> (City, town or county) <u>Wolfsville, Fred. Co. Md.</u> (State)			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Paul F. Bittle</u> ADDRESS <u>Myersville, Md.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>MAY 12 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>							



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07605 <span style="float: right;">07594</span>											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <span style="float: right;">21-1</span>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1101 Hamilton Blvd.</u>						d. STREET ADDRESS <u>1101 Hamilton Blvd.</u>					
3. NAME OF DECEASED (Type or print) First <u>Aaron</u> Middle <u>Martin</u> Last <u>Horst</u>						4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 24, 1880</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Funeral home &amp; cemetery</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Samuel E. Horst</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Martin</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-09-2672</u>		17. INFORMANT <u>Wm. A. Horst</u>		Address <u>Hagerstown, Md.</u> <u>1501 Pennsylvania Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease with congestive failure and hypertensive vascular disease, arteriosclerotic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>disease, arteriosclerotic</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 29</u> , 19 <u>65</u> , to <u>May 30</u> , 19 <u>66</u> , that <u>we</u> last saw the deceased alive on <u>May 29</u> , 19 <u>66</u> , and that death occurred at <u>3 A.</u> M. from the causes and on the date stated above.											
22a. SIGNATURE <u>B. B. Kneisley</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>June 1, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>						22d. ADDRESS <u>148 West Washington St. Hagerstown, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/2/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>					
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>						25a. REC'D BY REGISTRAR <u>JUN 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07606 Item 1c Film G377 6/6/66 07593									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cabin John				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital					d. STREET ADDRESS 6601 Seven Locks Road				
3. NAME OF DECEASED (Type or print) First Middle Last OLGA M TUCULANO					4. DATE OF DEATH Month Day Year 5-22-1966				
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-8-91		9. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Naples, Italy		12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME John Merolla	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 018-12-5441D		17. INFORMANT Daughter Mary E. Mattia		Address Same as Item 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Carcinomatosis (b) Carcinoma of Rt. Breast (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH Not known 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-27-1965 to 5-22-1966 that (I) (we) last saw the deceased alive on 5-21-1966 and that death occurred at 7:01 M, from the causes and on the date stated above.									
22a. SIGNATURE Arthur Riego				22b. DATE SIGNED 5-22-66				22c. PHYSICIAN'S NAME (Type) ARTHUR RIEGO	
22d. ADDRESS 1500 Penna. Ave., Hagerstown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5-25-66		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION (City, town or county) (State) Silver Spring, Maryland		
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR MAY 26 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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VR A15 (4)  
20 M 1/66

CERTIFICATE OF DEATH

07607

07596

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BIG POOL</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>BIG POOL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FLORENCE AMELIA JOHNSON</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>25</b> Year <b>19 66</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/1/1896</b>		9. AGE (In years last birthday) yrs. <b>70</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>BIG POOL, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE C. FRENCH</b>				14. MOTHER'S MAIDEN NAME <b>ANNA MANNING</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>235-32-1035</b>		17. INFORMANT Address <b>DANIEL G. JOHNSON, BIG POOL, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Failure</b> DUE TO (c) <b>Coronary occlusion</b>							INTERVAL BETWEEN ONSET AND DEATH <b>48 hr</b> <b>48 hr</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes &amp; Arteriosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/23/66</b> , 19__, to <b>5/25/66</b> , 19__, that (I) (we) last saw the deceased alive on <b>5/25/66</b> , 19__, and that death occurred at <b>7:05 P.</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Robert V. L. Campbell</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/27/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert V. L. Campbell</b>				22d. ADDRESS <b>Hagerstown Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/28/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SHANKTOWN CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>BIG POOL, WASH.CO., MD.</b>	
24. FUNERAL DIRECTOR <b>Richard J. Zrone Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR <b>JUN 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION

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BIG ROCK

WASHINGTON COUNTY HOSPITAL

FLORENCE ANITA JOHNSON

MAY

WHITE

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BIG ROCK, MARYLAND

HOUSEWIFE

ANNA MANNING

GEORGE O. FRENCH

10500-10500 WASHINGTON, BIG ROCK, MD.

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WASHINGTON COUNTY HOSPITAL

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WASHINGTON

10500



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

07608

07597

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Clearspring</u>				c. LENGTH OF STAY IN 1b <u>47 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R # 1</u>				d. STREET ADDRESS <u>R # 1</u>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Cora</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>May</u> Day <u>17</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 12, 1877</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Natural Bridge, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Samuel Whitesell</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Doran</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Delmar Johnson</u> Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia - &amp; Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>							
21. I certify that (I) (this hospital) attended the deceased from <u>1 May</u> , 19 <u>66</u> , to <u>17 May</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>16 May</u> , 19 <u>66</u> , and that death occurred at <u>3A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>J.D. Wilson</u>				22b. DATE SIGNED <u>5/17/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>J.D. Wilson M.D.</u>				22d. ADDRESS <u>580 Northern Ave. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/20/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Smithsburg Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Hard</u>				25a. REC'D BY REGISTRAR <u>MAY 19 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
Rest Haven Funeral Chapel Hagerstown, Md.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 6 Film G377 6/10/66 mh

CERTIFICATE OF DEATH

07609		07598	
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL</b>	c. LENGTH OF STAY IN 1b <b>20 YRS.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL 1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HOME</b>		d. STREET ADDRESS <b>HANCOCK MD.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GURNEY</b> Middle <b>LEE</b> Last <b>JOHNSTON</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>29</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 4 1904</b>
9. AGE (In years last birthday) yrs. <b>62</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>STANARDSVILLE VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM CONLEY</b>		14. MOTHER'S MAIDEN NAME <b>SELENA SHIFFETT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MARVIN B JOHNSTON RURAL 1 HANCOCK MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>4222</b> DUE TO (b) <b>Cardiovascular failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Pulmonary Edema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 20 1966</b> to <b>May 29 1966</b> , that (I) (we) last saw the deceased alive on <b>5/20 1966</b> , and that death occurred at <b>1205 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>L.M. Shaffer</b>		22b. DATE SIGNED <b>6/1/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L.M. SHAFFER</b>		22d. ADDRESS <b>HANCOCK MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>6.1.66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RIVERVIEW</b>	23d. LOCATION (City or Town) (County) (State) <b>HANCOCK WASHINGTON MD.</b>
24. FUNERAL DIRECTOR <b>Howard J. Grove Hancock Md</b>		25a. REC'D BY REGISTRAR <b>JUN 6 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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STANFORD VILLAGE VA.

M.D.A.

ILLIAM COBLEY

SELBY CHIEFTY

HOME

MARYLAND JOHNSTON RURAL 1 HANCOCK MD.

L.H. SHAFER

HANCOCK MD.

RURAL 6.1.06

RECEIVED

HANCOCK WASHINGTON MD.

CERTIFICATE OF DEATH

07610

07599

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b> c. LENGTH OF STAY IN TB <b>50yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Maryland</b> d. STREET ADDRESS <b>59 W. Bethel Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Pearl Frances Jones</b>		4. DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 9 1903</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>21</b>	11. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Sharpsburg, Md</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>David Herbert</b>	
14. MOTHER'S MAIDEN NAME <b>Fanny</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>220-30-7676</b>		17. INFORMANT <b>Alfred Jones 434 N. Jonathan St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>446X</b> DUE TO <b>UREMIA</b> Conditions, if any, which gave rise to immediate cause (b) <b>ARTERIOLE NEPHROSCLEROSIS</b> (a), stating the underlying cause test. (c) <b>ARTERIOSCLEROSIS, GEN.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10 April</b> , 19 <b>66</b> to <b>4 May</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4 May</b> , 19 <b>66</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>W.N. FENNER</b>		22b. DATE SIGNED <b>6 May 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>W.N. FENNER</b>		22d. ADDRESS <b>218 N. Potomac St. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5-7-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Hagerstown Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson</b>		25a. REC'D BY REGISTRAR <b>MAY 9 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO: THE SECRETARY OF DEFENSE  
FROM: THE SECRETARY OF DEFENSE  
SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07611

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07600

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural # 3</u>		c. LENGTH OF STAY IN lb <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural # 3</u>		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hagerstown</u>				d. STREET ADDRESS <u>Hagerstown</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Randy</u> Middle <u>Preston</u> Last <u>Kendle</u>				4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>19 66</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Sept. 17, 1947</u>		9. AGE (In years last birthday) <u>18</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Preston Miller Kendle Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Betty Marie Crawford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-46-2808</u>		17. INFORMANT <u>Mr. Preston M. Kendle</u> Address <u>Hagerstown, Md. R # 3</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> DUE TO <u>Mechanical obstruction of airway from accidental means.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>8304</u> (b) <u>  </u> (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Car slipped off ramp pinning patient underneath.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car slipped off ramp pinning patient underneath.</u>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>5:30</u> 5/11/66 p.m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Howard N. Weeks</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>5/12/66</u>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M. D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, & county) <u>580 Northern Ave. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/15/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash. Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. How</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
Rest Haven Funeral Chapel				Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MAY 17 1966

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WATER EXCHANGE CONTRACT

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1. The water exchange contract between the two parties is hereby acknowledged.

2. The water exchange contract between the two parties is hereby acknowledged.

3. The water exchange contract between the two parties is hereby acknowledged.

4. The water exchange contract between the two parties is hereby acknowledged.

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11. The water exchange contract between the two parties is hereby acknowledged.

12. The water exchange contract between the two parties is hereby acknowledged.

13. The water exchange contract between the two parties is hereby acknowledged.

14. The water exchange contract between the two parties is hereby acknowledged.

W. C. Hunt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send it to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07612

07601

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN b. <b>24 Hrs;</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>14 South Cannon Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Herbert</b> Last <b>Kershaw</b>			4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>1966</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 24, 1884</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Odd Fellows Hall</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Shepherdstown, W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Edward Kershaw</b>		
14. MOTHER'S MAIDEN NAME <b>Prudence Evans</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		
16. SOCIAL SECURITY NO. <b>214-09-9842</b>			17. INFORMANT <b>Mrs Elva P. Kershaw</b> Address <b>14 S. Cannon Ave/ Hagerstown, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Emphysema</b> 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic pulmonary infection</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>5/3/66</b>		20g. (County) <b>5/6/66</b>		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/3/66</b> , 19....., to <b>5/6/66</b> , 19....., that (I) (we) last saw the deceased alive on <b>5/6/66</b> , 19....., and the death occurred at <b>5/6/66</b> , M, from the causes and on the date stated above.					
22a. SIGNATURE <b>Howard N. Weeks</b>			22b. DATE SIGNED <b>5/7/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M. D.</b>			22d. ADDRESS <b>580 Northern Ave., Hagerstown, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 9, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>	
23d. LOCATION (City, town or county) <b>Williamsport, Maryland</b>		23e. REC'D BY REGISTRAR <b>Charles Judge</b>		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		24a. ADDRESS <b>Funeral Hagerstown, Md.</b>		24b. DATE <b>MAY 10 1966</b>	

VR A15 (4)  
15M 9/60

10892

07170

Geologic Columnary Information

MAY 10 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the remaining pages 1 and 2 to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

07613

CERTIFICATE OF DEATH

07602

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>8 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hagerstown</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>Rd 3</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ELSIE</b> Middle <b>DELLA</b> Last <b>LINEBAUGH</b>		4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/28/03</b>
9. AGE (In years lost birthday) yrs. <b>62</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Stanley, Va.</b>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Charles Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Betty Knight</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Charles J. Linebaugh, Sr. Hagerstown</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central Anoxia</b> 4201 DUE TO (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Atherosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>5/4</b> , 19 <b>66</b> , to <b>5/26</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>24 May 19 66</b> and that death occurred at <b>4P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>J. E. Gibson</b>		22b. DATE SIGNED <b>5/27/66</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5/28/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>
23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>			
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>Hagerstown, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>MAY 31 1966</b>	

30350

81350



## CERTIFICATE OF DEATH

07603

07614

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keedysville</b> c. LENGTH OF STAY IN 1b <b>20 Yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>60 N. Main St.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keedysville</b> 21-1 d. STREET ADDRESS <b>60 N. Main St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lula Eliza Lowe</b>		4. DATE OF DEATH Month Day Year <b>May 20, 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 22, 1885</b>
9. AGE (In years last birthday) <b>80</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>8 28</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Rural Downsview, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Alfred E. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Savilla Spielman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Raymond B. Lowe, 60 N. Main St.</b>		18. ADDRESS <b>Keedysville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute fulminant edema</b> 4200 DUE TO (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b> <b>7 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2-19-</b> , 19 <b>52</b> , to <b>5-20</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-20-</b> , 19 <b>66</b> , and that death occurred at <b>5 P M</b> , from causes on and the date stated above.			
22a. SIGNATURE <b>Joseph Secondari</b>		22b. DATE SIGNED <b>5-21-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH SECONDA RI</b>		22d. ADDRESS <b>BOONSBORO MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5-23-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bakersville Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Bakersville Wash. Co. Md.</b>
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 25 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

80012

CERTIFICATE OF MARRIAGE

1912

State of New York  
County of New York  
City of New York

On the 1st day of May, 1912, at New York, New York

I, the undersigned, a Justice of the Peace for the County of New York, do hereby certify that

the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of the County of New York

in and to which the original of the same has been duly filed for record

in the office of the County Clerk of the County of New York

at New York, New York, this 1st day of May, 1912

Witness my hand and the seal of the County of New York at New York, New York, this 1st day of May, 1912

Justice of the Peace for the County of New York

County of New York

City of New York

State of New York

County of New York

City of New York

State of New York

County of New York

City of New York

State of New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
07615						07604							
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport 21-1</u>				d. STREET ADDRESS <u>Rt. 1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WALLACE</u> Middle <u>Howard</u> Last <u>MATHENY</u>			4. DATE OF DEATH Month <u>5</u> Day <u>11</u> Year <u>1966</u>										
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/21/1892</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Augusta Co., Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William S. Matheny</u>				14. MOTHER'S MAIDEN NAME <u>ANNA HATTER</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>(If yes give war or dates of service)</u>		17. INFORMANT <u>SON</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable cardiac arrest</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____												INTERVAL BETWEEN ONSET AND DEATH <u>Found dead</u> <u>6 years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>10/18, 1965</u> to <u>5/11, 1966</u> , that (I) (we) last saw the deceased alive on <u>5/11 1966</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>John H. Hornbaker</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-11-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN H. HORNBAKER</u>				22d. ADDRESS <u>154 W. WASHINGTON ST JAGERSTOWN M.D.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/14/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Hill Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Lynchburg, Va.</u>							
24. FUNERAL DIRECTOR <u>WHITTEN FUNERAL HOME, Lynchburg, Virginia</u>				25a. REC'D BY REGISTRAR <u>MAY 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>							

152

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07616

## CERTIFICATE OF DEATH

07605

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>27 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Hospital County</b>				d. STREET ADDRESS <b>W. Washington St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA CHARLOTTE MATTSON</b>				4. DATE OF DEATH Month Day Year <b>MAY 23 1966</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17, 1878</b>	
9. AGE (In years last birthday) yrs. <b>88</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Sweden</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Sweden</b>				13. FATHER'S NAME <b>Ascar Samuelson</b>			
14. MOTHER'S MAIDEN NAME <b>Johnson</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>242-03-7864</b>				17. INFORMANT Address <b>Mrs. Velda Grimes Hagerstown, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4500</b> <b>Uremia</b> DUE TO (b) <b>Generalized atherosclerosis</b> DUE TO (c) <b>years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11 May 1966</b> , to <b>23 May 1966</b> , that (I) (we) last saw the deceased alive on <b>22 May 1966</b> , and that death occurred at <b>3A</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>J. L. Wilson</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/25/66</b>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Md.</b>	
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 31 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07617

## CERTIFICATE OF DEATH

07606

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>FRANKLIN</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD #2, HANCOCK, MARYLAND</b>	
c. LENGTH OF STAY IN 1b <b>3 WEEKS</b>		d. STREET ADDRESS <b>RFD #2, HANCOCK, MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MARTIN MANOR NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY MAGDALINE McDONALD</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/9/1885</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>FRANKLIN CO., PENNA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PHILLIP WARD</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET GARTNER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HARRY L. MC DONALD</b>		Address <b>RD#2 HANCOCK, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Repeated episodes of cerebral hemorrhage</b> (last episode <b>11</b> hours) 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease and cerebral atherosclerosis</b> (c) <b>70 months (certain)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 4</b> , 19 <b>66</b> , to <b>May 10</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>May 9</b> , 19 <b>66</b> , and that death occurred at <b>3:45</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>W. J. Layman M.D.</b>		22b. DATE SIGNED <b>May 11, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>		22d. ADDRESS <b>100 Professional Arts Bldg. Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5/19/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LITTLE COVE METHODIST</b>	23d. LOCATION (City or Town) (County) (State) <b>RURAL FRANKLIN CO., PENNA</b>
24. FUNERAL DIRECTOR <b>Richard J. Shawe Hancock Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 16 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

VR A15 (4)  
20 M 1/66

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12888

DATE OF BIRTH

12888

FRANKLIN

PENNSYLVANIA

WASHINGTON

STO. ST. HANCOCK, MARYLAND

3 WEEKS

HAGERSTOWN

STO. ST. HANCOCK, MARYLAND

MARTIN MARCH HURRING HORN

MARY

WOMAN

WOMAN

MARY

1911

1911

FEMALE WHITE

FRANKLIN CO., PENNA., U.S.A.

HOUSEWIFE

MARGARET CARTER

PHILIP WARD

HARRY L. TO DONALD HANCOCK, MD.

MD

XXXX

LITTLE DOVE METHODIST

WOMAN

WOMAN

NA 11 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

Item 20 Film G377 6/ MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07618						07607					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>						a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> <b>21-1</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>64 1/2 W. FRANKLIN STREET</b>						d. STREET ADDRESS <b>64 1/2 W. FRANKLIN STREET</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
<b>GARNETTA</b>			<b>LOUISE</b>			<b>MEARS</b>			<b>MAY 29 19 66</b>		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<b>FEMALE</b>		<b>WHITE</b>		<b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		<b>MAY 4, 1922</b>		<b>44 yrs.</b>		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>				11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MD.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>ARTHUR C. REYNOLDS</b>				14. MOTHER'S MAIDEN NAME <b>KATHERINE BURGER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>212-14-6240</b>				17. INFORMANT <b>WILLIAM REYNOLDS 342 S. CANNON AVE.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>aspiration and asphyxia</b> <b>9219</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>poss. alcohol ingestion</b>											
19. INTERVAL BETWEEN ONSET AND DEATH <b>seconds</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>A large mouthful of spaghetti blocking airway.</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 19 <b>59</b> , to <b>May 14</b> , 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>John C. Stauffer</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>5/31/1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>JOHN C. STAUFFER M.D.</b>						22d. ADDRESS <b>145 S. PROSPECT ST. HAGERSTOWN, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>JUNE 1, 1966</b>			23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>		
24. FUNERAL DIRECTOR <b>CHARLES M ROUZER HAGERSTOWN, MARYLAND</b>						25a. REC'D BY REGISTRAR <b>JUN 3 1966</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

113

WASHINGTON

RECEIVED

APR 11 1968

UNITED STATES DEPARTMENT OF JUSTICE

MEMO

TO : SAC, NEW YORK

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

DATE: 4/11/68



3/11/68

RE: [Illegible]

RE: [Illegible]

APR 11 1968

RE: [Illegible]

1 (M)  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07619

07608

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>225 Williams Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Lee Mentria</b>		4. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/12/12</b>
9. AGE (In years last birthday) <b>53 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>5</b> Days <b>3</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	
11. BIRTHPLACE (State or foreign country) <b>Mobile, Ala.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Levi Mentria</b>		14. MOTHER'S MAIDEN NAME <b>Callie Underwood</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>Mrs. Lucretia Milligan</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5810 Suspected cirrhosis of the liver; malnutrition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>QUE TO</b> (c) <b>QUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Howard N. Weeks, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		22. DATE SIGNED <b>5/16/66</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>REMOVED</b>		23b. DATE THEREOF <b>5/21/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Mobile, Alabama</b>	
24. FUNERAL DIRECTOR <b>Charles M. Ranges</b>		25a. REC'D BY REGISTRAR <b>Hagerstown Maryland</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		MAY 24 1966	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

912



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07620					07609				
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>8 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>SUTER AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>EDNA</b> First <b>PEARL</b> Middle <b>MICHAEL</b> Last			4. DATE OF DEATH <b>MAY</b> Month <b>31</b> Day <b>19</b> Year <b>66</b>						
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 23, 1898</b>		9. AGE (In years last birthday) <b>67</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAUNDRESS</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>LAUNDRY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON CO., MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL HOSE</b>					14. MOTHER'S MAIDEN NAME <b>ELIZABETH SUMAN</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>182-22-6729</b>		17. INFORMANT <b>MRS. ANNA BELLE ARNSBARGER</b> Address: <b>HAGERSTOWN, MD.</b> <b>RUAL ROUTE</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Thrombosis</b> <b>443 X</b> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE-ARTERIOSCLEROTIC C-V DISEASE</b> DUE TO (c) <b>ARTERIOSCLEROSIS, GEN.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b> <b>Yes.</b> <b>Yes.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>15 June</b> , 19 <b>65</b> , to <b>31 May</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>30 May</b> , 19 <b>66</b> , and that death occurred at <b>4:30</b> AM, from the causes and on the date stated above.									
22a. SIGNATURE <b>William N. Fender</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED <b>6/1/1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM N. FENDER M. D.</b>					22d. ADDRESS <b>218 N. POTOMAC ST. HAGERSTOWN, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>JUNE 2, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BROADFORDING CEM.</b>			23d. LOCATION (City, town or county) (State) <b>WASHINGTON CO., MARYLAND</b>	
24. FUNERAL DIRECTOR <b>CHARLES M. ROUZER</b>			ADDRESS <b>HAGERSTOWN, MARYLAND</b>			25a. REC'D BY REGISTRAR <b>JUN 6 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

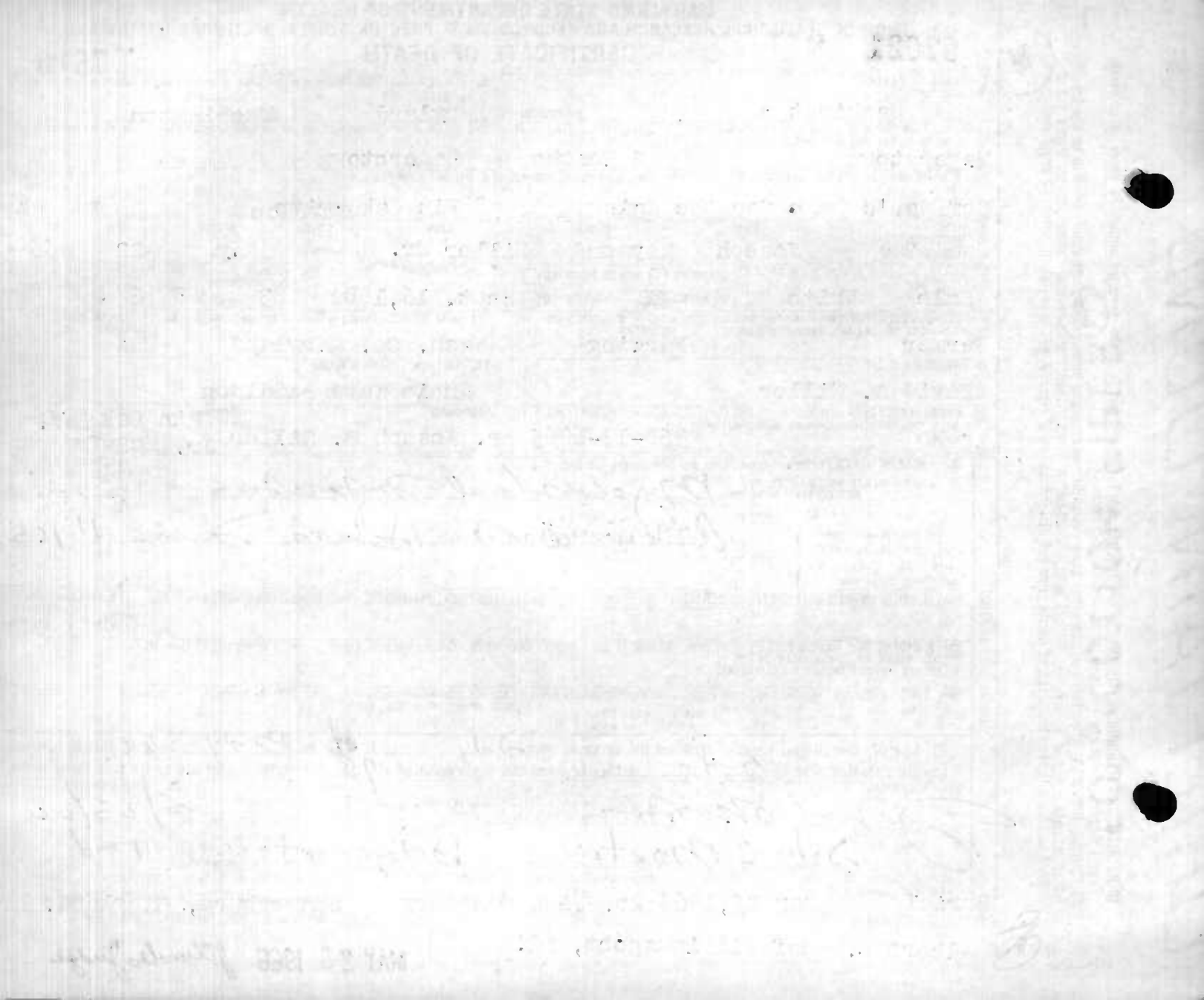
100-100000

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]  
[Illegible text follows, appearing to be a memorandum or report with several paragraphs of text, mostly obscured by heavy noise and bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>2 Months</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>21-1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Coffman's Home for the Aging</u>					d. STREET ADDRESS <u>8 Pin Oak Terrace</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Raymond</u> Last <u>Miller Sr.</u>					4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 16, 1882</u>		9. AGE (In years last birthday) <u>83</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash. Co. Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>David A. Miller</u>					14. MOTHER'S MAIDEN NAME <u>Annie Kate Paddison</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>356-12-6865</u>		17. INFORMANT Address <u>8 Pin Oak Terrace</u> <u>Mr. Joseph R. Miller Jr. Hagerstown</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>11 yrs.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>64</u> , to <u>May</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-4-</u> 19 <u>66</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Dr. C. Morton</u>				22b. DATE SIGNED <u>5/23/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Dr. C. Morton</u>				22d. ADDRESS <u>Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 25, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sharpsburg, Maryland.</u>			
24. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport, Md.</u>				25a. REC'D BY REGISTRAR <u>MAY 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



1M  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and must be filed within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07622

07611

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		Md. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Md.</b>		b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>		c. LENGTH OF STAY IN 1b <b>1day</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>33 South Main St.</b>		d. STREET ADDRESS <b>3530 Park Heights Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elden William Moser</b>		4. DATE OF DEATH Month Day Year <b>May 4 1966</b>					
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 18 1914</b>	
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gro. Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Wolfsville Fred.</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Hubert Moser</b>		14. MOTHER'S MAIDEN NAME <b>Della Coss</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-18-9311</b>		17. INFORMANT <b>Hubert Moser</b>		Address <b>Smithsburg Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> 4200 DUE TO (b) <b>Chronic Alcoholism</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <b>Several years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Hagerstown, Md.</b>		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <b>Dr. E. W. Ditto, Jr.</b>		M.D.		DATE SIGNED <b>5-6-66</b>			
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		Address (Street, city, town, or county) <b>Hagerstown, Md.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 7 1966</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cavetown Reform Cemetery</b>		22d. LOCATION (City, town, or country) <b>Cavetown Md.</b>		23. FUNERAL DIRECTOR ADDRESS <b>Minnich Funeral Home</b>		24a. REC'D BY REGISTRAR <b>MAY 9 1966</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07623											
07612											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 21-1						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Clearview Nursing Home</u>					d. STREET ADDRESS <u>250 Avon Road</u>						
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Laura</u> Last <u>Myers</u>					4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 7, 1886</u>		9. AGE (In years last birthday) <u>79</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Taneytown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>George A. Shoemaker</u>					14. MOTHER'S MAIDEN NAME <u>Martin</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO.					17. INFORMANT Address <u>Mr. Wm. E. Jacobs 250 Avon Rd. Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Atherosclerosis</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED while at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>11-1-</u> , 19 <u>65</u> , to <u>May 18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>May 18</u> , 19 <u>66</u> , and that death occurred at <u>2</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert P. Conrad</u>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-19-66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>					22d. ADDRESS <u>137 W. Washington Hagerstown, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>5/24/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>				
24. FUNERAL DIRECTOR <u>Wm. C. Hoot</u> <u>Rest Haven Funeral Chapel</u>					ADDRESS <u>Hagerstown, Md.</u>		25. REC'D BY REGISTRAR DATE <u>MAY 20 1966</u>				
							25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07624

07613

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>6 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GATEWAY CONVALESCENT HOME</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HANCOCK</b> d. STREET ADDRESS <b>RURAL HANCOCK</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>TALCOTT ELIASON NORRIS</b>		4. DATE OF DEATH Month Day Year <b>MAY 8 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/31/1884</b>
9. AGE (In years lost birthday) yrs. <b>82</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>W. MD. RAILROAD</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>AMBROSE NORRIS</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE ROBERTS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>WILLIAM NORRIS RFD #1, HANCOCK, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Atherosclerosis</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis, etc.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>Yes.</b>
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5 June 1963</b> , to <b>8 May 1966</b> , that (I) (we) last saw the deceased alive on <b>5 May 1966</b> , and that death occurred at <b>6:30 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>W. N. FENDER</b>		22b. DATE SIGNED <b>10 May 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. N. FENDER</b>		22d. ADDRESS <b>210 N. Potomac St. Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>5/12/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PINEY PLAINS</b>	23d. LOCATION (City or Town) (County) (State) <b>ALLEGANY CO. MARYLAND</b>
24. FUNERAL DIRECTOR <b>Richard J. Lane Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 13 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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WASHINGTON WASHINGTON

RURAL HAGERSTOWN 10 YEARS RURAL HAGERSTOWN

BATTERY COMVALESCENT HOME RURAL HAGERSTOWN

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WHITE WHITE

W. NO. RAILROAD WASHINGTON, MARYLAND, U.S.A.

AMBERGEE HOBBS CAROLINE HOBBS

WILLIAM HOBBS DEB. WASHINGTON, MD.

WASHINGTON, D.C. MAY 13 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
07625					07614										
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)										
a. COUNTY Washington					a. STATE Maryland										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					b. COUNTY Washington										
c. LENGTH OF STAY IN 1b 5 Years					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown										
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 336 Devonshire Road					d. STREET ADDRESS 316 W. Washington St.										
3. NAME OF DECEASED (Type or print) First Middle Last ALBERT HOWARD ORCUTT					4. DATE OF DEATH Month Day Year May 2, 1966										
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 17, 1876		9. AGE (In years last birthday) yrs. 89							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cutter		10b. KIND OF BUSINESS OR INDUSTRY Southern Shoe Co.		11. BIRTHPLACE (County & State, or foreign country) Hag. Wash. Co, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
13. FATHER'S NAME Ephraim Orcutt					14. MOTHER'S MAIDEN NAME Barbara A. Smith										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO. 219-20-4381					17. INFORMANT Address Mrs. Pauline Kipe 336 Devonshire Road, Hagerstown, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4221 DUE TO (b) Senility Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 years										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										21. I certify that (I) (this hospital) attended the deceased from 3-31-1966 to 5-2-1966, that (I) (we) last saw the deceased alive on 4-8-1966, and that death occurred at 8:15, from the causes and on the date stated above.					
22a. SIGNATURE Dr. E. W. Ditto, Jr.					ATTENDING MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. 5-3-66					22b. DATE SIGNED 5-3-66					
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.					22d. ADDRESS 215 W. Washington St., Hagerstown, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF May 5, 1966		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City, town or county) (State) Hag. Wash. Co, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown, Md.					25a. REC'D BY REGISTRAR MAY 6 1966					25b. REGISTRAR'S SIGNATURE Charles Judge					

1952

CONFIDENTIAL

SECRET

215 W. Washington St., Haverhill, Mass.

Dr. J. J. White, Jr.

MAY 6 1952

Dr. J. J. White, Jr.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07626					07615				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. CDUNTY Washington MARYLAND					a. STATE Maryland b. COUNTY Washington				
b. CITY OR TDWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 39 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown 21-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS 135 John Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First Middle Last		4. DATE OF DEATH		Month Day Year		
Margaret Belle Pike					May 3 1966				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 18, 1882		9. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (County & State, or foreign country) Antrim Twp. Franklin Co. Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Stickel					14. MOTHER'S MAIDEN NAME Sarah Vandrew				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFDRMANT Mr. Geo. L. Pike		Address 135 John Street Hagerstown, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Auricular, followed by ventricular fibrillation DUE TO (b) Hypertensive and atherosclerotic heart disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus; rheumatoid arthritis; carcinoma sigmoid with metastasis to regional nodes and liver									INTERVAL BETWEEN ONSET AND DEATH 1 hour 14 years (certain)
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from April 30, 1966, to May 3, 1966, that (I) (we) last saw the deceased alive on May 3, 1966, and that death occurred at 10:10 from the causes and on the date stated above.									
22a. SIGNATURE W. T. Layman, M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 4, 1966		
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.					22d. ADDRESS 800 Professional Arts Bldg. Hagerstown, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/7/66		23c. NAME OF CEMETERY OR CREMATORY Macedonia Church Cemetery		23d. LOCATION (City, town or county) (State) Nr. Greencastle Penna.		
24. FUNERAL DIRECTOR W. A. Hunt					ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.		25a. REC'D BY REGISTRAR MAY 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge

Wm. C. Clark  
MAY 1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

M

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>4 YRS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
f. STREET ADDRESS <b>100 INDIAN COTTAGE RD.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARIE</b> Middle <b>PLANTE</b> Last <b>PLANTE</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>14</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/20/1908</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>57</b> Days <b>14</b> Hours <b>14</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
12. BIRTHPLACE (County & State, or foreign country) <b>RUSSIA</b>		13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. FATHER'S NAME <b>UNKNOWN</b>		15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		17. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>156-09-3323</b>	
18. INFORMATANT <b>MR RAMICK PLANTE</b>		19. ADDRESS <b>HAGERSTOWN MD.</b>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Cervix</b> 171X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma of Cervix</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>2 yrs</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/1</b> , 19 <b>65</b> , to <b>3/14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>3/14</b> , 19 <b>66</b> , and that death occurred at <b>3:15 P.M.</b> from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <b>Donald E. Martin</b>		22c. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <b>Donald E. Martin M.D.</b>		22e. ADDRESS <b>418 N. Potomac St. Hagerstown</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/17/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN MD.</b>	
24. FUNERAL DIRECTOR <b>W. J. Norman Hagerstown Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07628

CERTIFICATE OF DEATH

07617

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN Tb <b>78yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>1341 Jefferson Blvd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Co. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNIE ELIZABETH PLUMMER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1966</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>Nov. 27, 1887</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Bridgeport, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Bridgeport, Maryland</b>	
13. FATHER'S NAME <b>Frederich H. Plummer</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Craley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Miss Jeannette Plummer, Hagerstown Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO (b) <b>Hypertensive vascular disease, arteriosclerotic</b> DUE TO (c) <b>Indefinite</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 15, 1966</b> , to <b>May 20, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 19, 1966</b> , and that death occurred at <b>3:30A.</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <b>B. B. Kneisley</b>		22b. DATE SIGNED <b>5/20/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		22d. ADDRESS <b>148 West Washington St. Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 23, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Md.</b>	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 26 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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UNITED STATES OF AMERICA

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Washington, D.C.

Department of State

Mr. Secretary

Mr. Secretary

Washington, D.C.

Washington, D.C.

Dear Sir:

Dear Sir:

Very truly yours,

Very truly yours,

Robert H. Jackson

Robert H. Jackson

cc

cc

Enclosure

Enclosure

Very truly yours,

Very truly yours,

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Very truly yours,

Very truly yours,

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Very truly yours,

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Very truly yours,

Very truly yours,



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>WASHINGTON</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1601 VIRGINIA AVE.</b>					d. STREET ADDRESS <b>1601 VIRGINIA AVE.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First <b>WALTER</b>		Middle <b>POMPELL</b>		Last <b>POMPELL</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>21</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/27/1903</b>		9. AGE (In years last birthday) <b>62</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FINISHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SILK RIBBON CO.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>ROBERT POMPELL</b>					14. MOTHER'S MAIDEN NAME <b>BESSIE WILKINSON</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-3162</b>		17. INFORMANT <b>MRS. PAULINE POMPELL</b>			Address <b>HAGERSTOWN MD.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cop. Pulmonale</b> 241X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Pulmonary Emphysema &amp; Stenosis</b> DUE TO (c) <b>Bronchial Asthma</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Hagerstown</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1966</b> to <b>May 21 1966</b> , that (I) (we) last saw the deceased alive on <b>May 21 1966</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Philip J. Hirshman</b>					22b. DATE SIGNED <b>5/23/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		
22d. ADDRESS <b>159 W. Washington St., Hagerstown, Md.</b>					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/24/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		23d. LOCATION (City, town or county) <b>HAGERSTOWN MD.</b>		(State)	
24. FUNERAL DIRECTOR <b>W. J. Norment, Hagerstown, Md.</b>					25a. REC'D BY REGISTRAR <b>MAY 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>3 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Flintstone</u> 01-2				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Maryland State Hospital</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Mae</u> Last <u>Reed</u>					4. DATE OF DEATH Month <u>5</u> Day <u>25</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/27/28</u>		9. AGE (In years last birthday) <u>39</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maysville, W. Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>George Van Meter</u>					14. MOTHER'S MAIDEN NAME <u>Rose Rhorbaugh</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Edward Reed, Flintstone, Md. - Husband</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH. <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pseudo Bulbar Palsy</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>5-14-1966</u> to <u>5-25-1966</u> , that (I) (we) last saw the deceased alive on <u>5-25-1966</u> , and that death occurred at <u>11:45</u> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>					22b. DATE SIGNED <u>5-25-66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Arthur Riegg</u>					22d. ADDRESS <u>1500 Penna. Ave. Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 29, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Cumberland, Md.</u>		
24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>					25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MAY 31 1966

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3001 T.S. TAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07631					07620				
1. PLACE OF DEATH a. COUNTY WASHINGTON					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON				
b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			d. STREET ADDRESS 27 WEST SIDE AVE.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last JOHN WOODROW REEDY			4. DATE OF DEATH Month Day Year MAY 24 19 66						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/16/1916		9. AGE (In years last birthday) 49 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY TUCK TERMINAL		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN L. REEDY					14. MOTHER'S MAIDEN NAME MARY EDITH MARTIN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-1560		17. INFORMANT MRS. AMELIA M. REEDY			Address: HAGERSTOWN MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Failure</i> 5811 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Liver Cirrhosis</i> DUE TO (c) <i>Chronic Alcoholism</i> INTERVAL BETWEEN ONSET AND DEATH 2 w 4 d 5 yrs. 15 yrs.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>hypertension</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 10-30-64, 19 55, to 5-24-66, 19 66, that (I) (we) last saw the deceased alive on 5-24-66, 19 66, and that death occurred at 11:55 P.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>John C. Morton</i> 22c. PHYSICIAN'S NAME (Type) John C. Morton, M. D.					22b. DATE SIGNED 5-27-66		22d. ADDRESS 580 Northern Ave., Hagerstown, Md.		
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE THEREOF 5/28/66		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City, town or county) HAGERSTOWN		(State) MD.	
24. FUNERAL DIRECTOR <i>W. J. Horment, Hagerstown, Md.</i>					25a. REC'D BY REGISTRAR JUN 2 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07632											
1. PLACE OF DEATH a. CDUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>65 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WESTERN MARYLAND STATE HOSP.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. CDUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> d. STREET ADDRESS <u>378 E. FRANKLIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Gertrude Elizabeth Reesman</u> First Middle Last						4. DATE OF DEATH <u>5-22-1966</u> Month Day Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/18/1882</u>		9. AGE (In years last birthday) <u>83 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN A. GRIFFITH</u>						14. MOTHER'S MAIDEN NAME <u>CELIA MILLER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>219-54-0103</u>		17. INFORMANT <u>MRS. MARGARET HARTMAN</u> Address <u>HAGERSTOWN MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Not known</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5-17-1966</u> , to <u>5-22-1966</u> , that (I) (we) last saw the deceased alive on <u>5-22-1966</u> , and that death occurred at <u>5:45 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>5-22-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Arturo Riego</u>						22d. ADDRESS <u>1000 Penna. ave. Hagerstown</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5/25/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EV. LUTHERN CHURCH</u>		23d. LOCATION (City, town or county) (State) <u>FAIRFIELD, PENNA.</u>					
24. FUNERAL DIRECTOR <u>W. J. Korman, Hagerstown, Md.</u>						25a. REC'D BY REGISTRAR <u>MAY 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

Frank White  
Vertrude Elisabeth Kriem

Augustine's (Catherine's) Heart  
Cribbed (Shorthand)

John  
Mr. Laro Rico 1000  
May 20 1856

07633

## CERTIFICATE OF DEATH

07622

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN lb <b>4 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Boonsboro Rfd. 2</b> d. STREET ADDRESS <b>Mt. Lena</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna Louise Renner</b>		4. DATE OF DEATH Month Day Year <b>May 10, 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1878</b>
9. AGE (In years last birthday) <b>88 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>0 28</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Frederick Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Kephart</b>		14. MOTHER'S MAIDEN NAME <b>Frances Younkens</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>217-32-5739</b>	
17. INFORMANT <b>Mrs. Ethel B. Needy Boonsboro Rfd. 2, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Nephrosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>2 yrs.</b> <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diverticulosis of colon</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9-13</b> , 19 <b>62</b> , to <b>5-10, 1966</b> , that (I) (we) last saw the deceased alive on <b>5-9</b> , 19 <b>66</b> , and that death occurred at <b>9:10 a.m.</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>Charles F. Hess</i>		22b. DATE SIGNED <b>5-11-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles F. Hess, M.D.</b>		22d. ADDRESS <b>Smithsburg, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5-12-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lena Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Mt. Lena, Wash. Co. Md.</b>
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 16 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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58333

CONTINUED OF NEW

1. Name of the person

1. Name of the person

2. Date of birth

2. Date of birth

3. Sex

3. Sex

4. Place of birth

4. Place of birth

5. Date of entry

5. Date of entry

6. Name of the vessel

6. Name of the vessel

7. Name of the agent

7. Name of the agent

8. Name of the master

8. Name of the master

9. Name of the owner

9. Name of the owner

10. Name of the charterer

10. Name of the charterer

11. Name of the consignee

11. Name of the consignee

12. Name of the broker

12. Name of the broker

13. Name of the agent

13. Name of the agent

14. Name of the master

14. Name of the master

15. Name of the owner

15. Name of the owner

16. Name of the charterer

16. Name of the charterer

17. Name of the consignee

17. Name of the consignee

18. Name of the broker

18. Name of the broker

MADE IN U.S.A.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07623

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hagerstown</b> c. LENGTH OF STAY IN 1b <b>15 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rd # 4</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hagerstown</b> d. STREET ADDRESS <b>Rd # 4</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Douglas Michael Repp</b>			4. DATE OF DEATH <b>May 14 19 66</b>				
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/18/51</b>	9. AGE (In years last birthday) <b>15 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>high school</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>			
13. FATHER'S NAME <b>Harry D. Repp, Jr.</b>			14. MOTHER'S MAIDEN NAME <b>Bernadine Brown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Harry D. Repp, Jr. Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Fractured skull</b> 8234 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Pt. was killed instantly when car hit culvert on Rt. 63.</b>					
20c. TIME OF INJURY Month, Day, Year, Hour a.m., p.m. <b>12 midnight 5/14 19 66</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway-Rt. 63</b>			
20f. (City or town) <b>Washington</b>		(County) (State) <b>Md.</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Howard N. Weeks</b>		EXAMINER'S NAME (Type) <b>Howard N. Weeks, M.D.</b>		22. DATE SIGNED <b>5/16/66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5/16/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			
23d. LOCATION (City, town or county) <b>Hagerstown, Md.</b>		(State)					
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b>		ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 17 1966</b>			
				25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and retain page 4 until the remains are interred.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07635

CERTIFICATE OF DEATH

07624

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN Tb <b>2 weeks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>209 Manse Road</b>		d. STREET ADDRESS <b>Baltimore Street</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLOTTE MAE RITTER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/3/30</b>
9. AGE (In years last birthday) <b>35</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>resturant</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Ralph Ritter</b>		14. MOTHER'S MAIDEN NAME <b>Beulah Henry</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-28-6177</b>	
17. INFORMANT <b>/ Ralph Ritter</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>170X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of Lys Breast</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>see 10-1865</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 10</b> , 19 <b>65</b> , to <b>May 16</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>May 16</b> , 19 <b>66</b> , and that death occurred at <b>6 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Sidney Novenstein</b>		22b. DATE SIGNED <b>5-17-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN</b>		22d. ADDRESS <b>FUNKSTOWN MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5/18/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Green Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Waynesboro, Penna.</b>	
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>MAY 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>4 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hagerstown</b> 21-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>RFD 2</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>CATHERINE</b> Last <b>ROBINSON</b>		4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 19, 1917</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>resturant</b>	9. AGE (In years last birthday) yrs. <b>48</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Mercersburg, Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert Timmons</b>		14. MOTHER'S MAIDEN NAME <b>Irene Saunders</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-20-9565</b>	
17. INFORMANT <b>John Robinson, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Artery Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Diabetes Mellitus.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 weeks</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 21 1966</b> , to <b>May 21 1966</b> , that (I) (we) last saw the deceased alive on <b>May 21 1966</b> , and that death occurred at <b>2:35 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Charles C. Spencer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Charles C. Spencer, M. D.</b>		22d. ADDRESS <b>145 S. Prospect Street Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>5-24-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 26 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

OFFICE OF THE SECRETARY OF THE NAVY

1936

Washington, D.C.

Mr. [Name] [Address] [City] [State] [Zip]

Dear Sir:

I am pleased to hear from you and in reply to inform you that your letter of [Date] has been received.

Enclosed for you are [Number] copies of [Document Name] as requested.

Very truly yours,

[Signature]

[Title]

[Address]

[City]

[State]

[Zip]

[Phone Number]

[Fax Number]

[E-mail Address]

[Web Address]

[Social Media Links]

[Footer Information]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																													
07637					07626																								
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE																								
WASHINGTON MARYLAND					MARYLAND WASHINGTON																								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b																									
HAGERSTOWN				5 MIN.																									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS																								
WASHINGTON COUNTY HOSPITAL					WOODSIDE DRIVE																								
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH																								
First Middle Last					Month Day Year																								
PASQUALE N.M.N. ROMUALDI					MAY 18 19 66																								
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)																					
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		JAN. 29, 1893		73 yrs.																					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?																					
BAKER				FOOD MANUF.		ITALY		U.S.A.																					
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME																								
UNKNOWN					UNKNOWN																								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address																			
NO					176-03--0642					MARY PARIS R.D.# 3 HAGERSTOWN, MD.																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE-ARTERIOSCLEROTIC C-V DISEASE DUE TO (c) ARTERIOSCLEROSIS, COR. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS										INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs. Yes. Yes.																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)														
21. I certify that (I) (this hospital) attended the deceased from Feb-15, 1966, to May 18, 1966, that (I) (we) last saw the deceased alive on May 18, 1966, and that death occurred at 4 P M, from the causes and on the date stated above.										22a. SIGNATURE WILLIAM N. FENDER M.D.										22b. DATE SIGNED 5/18/1966									
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS																			
WILLIAM N. FENDER M.D.										218 N. POTOMAC ST. HAGERSTOWN, MD.																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City, town or county) (State)														
REMOVAL					MAY 18, 1966					ST. RITA CEMETERY					CONNELLSVILLE, PENNA.														
24. FUNERAL DIRECTOR Charles M. Lauge										HAGERSTOWN, MARYLAND										25a. REC'D BY REGISTRAR MAY 23 1966					25b. REGISTRAR'S SIGNATURE Charles Judge				

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WASHINGTON

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WASHINGTON STATE DEPARTMENT

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VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
07638					CERTIFICATE OF DEATH					07627				
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>1 year</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> 21-1									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garlock Convalescent Home</b>					d. STREET ADDRESS <b>823 Spruce St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <b>AMOS RAY RUTH</b>					4. DATE OF DEATH Month Day Year <b>May 23 19 66</b>									
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/6/86</b>		9. AGE (In years last birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>supervisor</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>refrigeration</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Roxburg, Md.</b>			12. CITIZEN OF WHAT COUNTRY?						
13. FATHER'S NAME <b>William Ruth</b>					14. MOTHER'S MAIDEN NAME <b>Mary Sprecher</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>214-09-1558</b>		17. INFORMANT Address <b>Mrs. Jane Domenici Hagerstown, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>2 years</b>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>April 15</b> , 19 <b>66</b> , to <b>May 23</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>May 23</b> , 19 <b>66</b> , and that death occurred on <b>May 23</b> , 19 <b>66</b> , from causes and on the date stated above.														
22a. SIGNATURE <i>[Signature]</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>5-24-66</b>						
22c. PHYSICIAN'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>					22d. ADDRESS <b>Hagerstown, Md.</b>									
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>							
24. FUNERAL DIRECTOR ADDRESS <b>MINNICH FUNERAL HOME Hagerstown, Md.</b>					25a. REC'D BY REGISTRAR <b>MAY 26 1966</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

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STATEMENT OF DEATH

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MAY 1968

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) STATE <u>Washington</u> <u>Clear Spring (East)</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clear Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood <del>1000</del> Church Home</u>		d. STREET ADDRESS <u>2750 Va. Ave. Williamsport</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mary Ida Seibert</u>		<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-29-1886</u>
9. AGE (In years last birthday) yrs. <u>79</u>		IF UNDER 1 YEAR: Months <u>9</u> Days <u>8</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS.: <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Washington</u>	
13. FATHER'S NAME <u>Charles Frederick Sowers</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Heller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Mark G. Wagner</u>		Address <u>2750 Va. Ave. Wmpt.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Abdominal Carcinomatosis</u> DUE TO <u>154X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adeno CA of Rectosigmoid</u> DUE TO <u>1 yr</u> (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>MEDICAL CERTIFICATION</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2-28</u> 19 <u>66</u> to <u>5-7</u> 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>5-6</u> 19 <u>66</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert P. Conrad</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>5-7-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert P. Conrad</u>		22d. ADDRESS <u>137 W. Washington Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		23b. DATE THEREOF <u>5/7/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Funeral Home</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rowland Funeral Home</u>		ADDRESS <u>Clear Spring Md.</u>	
25a. REC'D BY REGISTRAR <u>MAY 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>	c. LENGTH OF STAY IN TB <b>1 year</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Reeder Nursing Home</b>		d. STREET ADDRESS <b>85 N. Colonial Dr.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>JACOB BENJAMIN SHANK</b>		4. DATE OF DEATH Month Day Year <b>May 19 1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>1/13/90</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>barber shop</b>	9. AGE (In years last birthday) yrs. <b>76</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>David Shank</b>		14. MOTHER'S MAIDEN NAME <b>Clara Miller</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-18-7372</b>	17. INFORMANT <b>Mrs. Mary Shank</b> Address <b>Hagerstown</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200</b> <b>arteriosclerotic heart disease</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 4, 1965</b> to <b>May 19 1966</b> that (I) (we) last saw the deceased alive on <b>May 18, 1966</b> , and that death occurred at <b>3A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>G. W. He Van</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>5/20/66</b>
22c. PHYSICIAN'S NAME (Type) <b>G. W. He Van</b>		22d. ADDRESS <b>Boonsboro, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/21/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Miller's Church Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Leitersburg Md.</b>
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b>		ADDRESS <b>Hagerstown, Md.</b>	25a. REC'D BY REGISTRAR <b>MAY 23 1966</b>
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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OFFICE OF THE SECRETARY OF THE ARMY

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07641											
07630											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>MARYLAND</b> <b>WASHINGTON</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>3YRS. 6 MOS.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				d. STREET ADDRESS <b>539 REYNOLDS AVENUE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>JACKSON CONV. HOME</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>ELLIOTT</b> Last <b>SHAW</b>			4. DATE OF DEATH Month <b>MAY</b> Day <b>4</b> Year <b>1966</b>								
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 10, 1870</b>		9. AGE (In years last birthday) <b>95</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OWNER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MILLINERY SHOP</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ALLEGANY CO., MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>HENRY C. SHAW</b>						14. MOTHER'S MAIDEN NAME <b>MARY E. BOAK</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>WALTER S. MILLER 533 REYNOLDS AVE</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Repeated hemorrhage from intestinal tract</b> <b>578X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prolapse of rectum</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Atherosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>2 years</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 24</b> , <b>1966</b> , to <b>May 4</b> , <b>1966</b> , that (I) (we) last saw the deceased alive on <b>April 29</b> , <b>1966</b> , and that death occurred at <b>9:00 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>William T. Layman</b>						22b. DATE SIGNED <b>5/5/ 1966</b>					
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM T. LAYMAN M.D.</b>						22d. ADDRESS <b>PROFESSIONAL ARTS BLDG. HAGERSTOWN, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>MAY 7, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>Charles M. Kueper</b>						25a. REC'D BY REGISTRAR <b>MAY 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>					d. STREET ADDRESS <b>727 MEDWAY ROAD</b>				
3. NAME OF DECEASED (Type or print) First <b>ARTHUR</b> Middle <b>CLARENCE</b> Last <b>SHEARER, SR.</b>					4. DATE OF DEATH Month <b>MAY</b> Day <b>16</b> Year <b>1966</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 18, 1904</b>		9. AGE (In years last birthday) <b>61</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GRINDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MACHINE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FRANKLIN CO., PENNA.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>GEORGE W. SHEARER</b>					14. MOTHER'S MAIDEN NAME <b>ELIZABETH CONNER</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>214-09-0263</b>		17. INFORMANT <b>HAGERSTOWN, MARYLAND</b> <b>MRS. ANNA SHEARER 727 MEDWAY ROAD</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right ventricular cardiac failure</b> 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary fibrosis, advanced, and chronic</b> DUE TO <b>bronchopulmonary obstructive disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>Long-standing</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 12, 1963</b> to <b>May 16, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 16, 1966</b> , and that death occurred at <b>9:20P.</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>B.B. KNEISLEY M.D.</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>MAY, 18, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>B.B. KNEISLEY M.D.</b>					22d. ADDRESS <b>148 W. WASHINGTON ST. HAGERSTOWN, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 19, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>WASHINGTON CO., MARYLAND</b>		
24. FUNERAL DIRECTOR <b>Charles M. Jones</b>					ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>MAY 23 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

WASHINGTON, D.C. 20535  
JULY 19, 1966

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]

RE: NEW YORK TELETYPE TO BUREAU, JULY 18, 1966.

ENCLOSED FOR THE BUREAU ARE TWO COPIES OF A LETTER  
DATED JULY 18, 1966, FROM THE NEW YORK OFFICE TO THE  
BUREAU.

THE NEW YORK OFFICE IS CURRENTLY CONDUCTING AN  
INVESTIGATION OF THE MATTER.

VERY TRULY YOURS,  
[illegible signature]

ADMINISTRATIVE: [illegible]

ADMINISTRATIVE: [illegible]

ADMINISTRATIVE: [illegible]

ADMINISTRATIVE: [illegible]

ADMINISTRATIVE: [illegible]

ADMINISTRATIVE: [illegible]

ADMINISTRATIVE: [illegible]

ADMINISTRATIVE: [illegible]

ADMINISTRATIVE: [illegible]

ADMINISTRATIVE: [illegible]

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Franklin				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Waynesboro, 75-3				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS 225 South Potomac Street				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last RICHARD THEODORE SLAYBAUGH					4. DATE OF DEATH Month Day Year May 23, 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-20-25		9. AGE (In years last birthday) 40 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fire Department		10b. KIND OF BUSINESS OR INDUSTRY Fort Ritchie		11. BIRTHPLACE (County & State, or foreign country) Fayetteville, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Mervin Slaybaugh					14. MOTHER'S MAIDEN NAME Bertha Peterson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes B/11/44 - 4/30/46					16. SOCIAL SECURITY NO. 201-18-7363				
17. INFORMANT Mrs. Patricia Slaybaugh, Waynesboro Pa.					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain stem infarction 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Vertebro-basilar thrombosis DUE TO (c) Atherosclerosis of vertebral & basilar arteries several days several days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 5-21-1966, to May 23, 1966, that (I) (we) last saw the deceased alive on May 23, 1966, and that death occurred at 10:10 PM, from the causes and on the date stated above.									
22a. SIGNATURE A. F. Abdullah, M. D.					22b. DATE SIGNED 5-24-66				
22c. PHYSICIAN'S NAME (Type) A. F. Abdullah, M. D.					22d. ADDRESS 132 North Potomac Street, Hagerstown,				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/26/66		23c. NAME OF CEMETERY OR CREMATORY Green Hill			23d. LOCATION (City, town or county) (State) Waynesboro, Franklin Co., Pa.	
24. FUNERAL DIRECTOR Walter J. Grove					25a. REC'D BY REGISTRAR MAY 27 1966				
25b. REGISTRAR'S SIGNATURE Charles Judge									





## CERTIFICATE OF DEATH

07633

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rohrersville</b> c. LENGTH OF STAY IN lb <b>57 Yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rohrersville</b> 21-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Orville Harrison Slifer</b>		4. DATE OF DEATH Month Day Year <b>May 29, 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1888</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>1 10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Broad Run, Fred. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Slifer</b>		14. MOTHER'S MAIDEN NAME <b>Etta Mullendore</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>705-10-3650</b>	
17. INFORMANT <b>Mrs. Eva F. Slifer, Rohrersville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarct</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>Years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-25-</b> , 19 <b>65</b> , to <b>6-29-</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>6-28-</b> , 19 <b>66</b> , and that death occurred at <b>7A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Hewitt</b>		22b. DATE SIGNED <b>6-1-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH SECONDARI</b>		22d. ADDRESS <b>Boonsboro Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-31-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rohrersville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rohrersville, Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md</b>		25a. REC'D BY REGISTRAR <b>JUN 6 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF NEW YORK

1883

1883

IN SENATE, January 1, 1883.

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1882.

ALBANY:

JOHN B. LEECH, PRINTERS.

1883.

THE STATE OF NEW YORK.

IN SENATE, January 1, 1883.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07634

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>335 Belview Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elva Naomi Smith</b>		4. DATE OF DEATH Month Day Year <b>May 23 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/1/1890</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Clintondale, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Levi Quick</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ida Hornebeck</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Address <b>Mr. Harold W. Smith Jr.-5/9 May St. Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease with</b> <b>443X</b> DUE TO <b>congestive failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Indefinite</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 8</b> , 19 <b>63</b> , to <b>May 23</b> , 19 <b>66</b> , that I last saw the deceased alive on <b>May 22</b> , 19 <b>66</b> , and that death occurred at <b>7:30A.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>B. B. Kneisley</b>		ADDRESS (Street, city or town, state) <b>148 West Washington St. Hagerstown, Maryland</b>	
DATE SIGNED <b>5/23/66</b>			
PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entomb</b>		22b. DATE THEREOF <b>5/26/66</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>6 E. Franklin St. Balt. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers-8728 Liberty Rd. Randallstown, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 26 1966</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# CERTIFICATE OF DEATH

07646

07635

1. PLACE OF DEATH o. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 Months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		<b>21-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>29 South Locust Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First <b>LEONARD</b>		Middle <b>SMITH</b>		Last	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>1966</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Feed Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Boonsboro, Wash. Co., Md.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Feed Store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Boonsboro, Wash. Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Martin L. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Susan Emmert</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Irene Cunningham 29 S. Locust St</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke (left hemiplegia)</b> 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cerebral vascular thrombosis</b> (c) <b>cerebral arteriosclerosis</b>		Hagerstown, Maryland		INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>basilar pneumonias</b>		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <b>May 14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>May 13</b> , 19 <b>66</b> , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <b>John C. Stauffer</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>John C. Stauffer</b>		22d. ADDRESS <b>145 So. Prospect St, Hag. Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 17, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery Hag. Wash. Co., Md.</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Andrew K. Coffman Hagerstown, Maryland</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>MAY 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal abroad in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

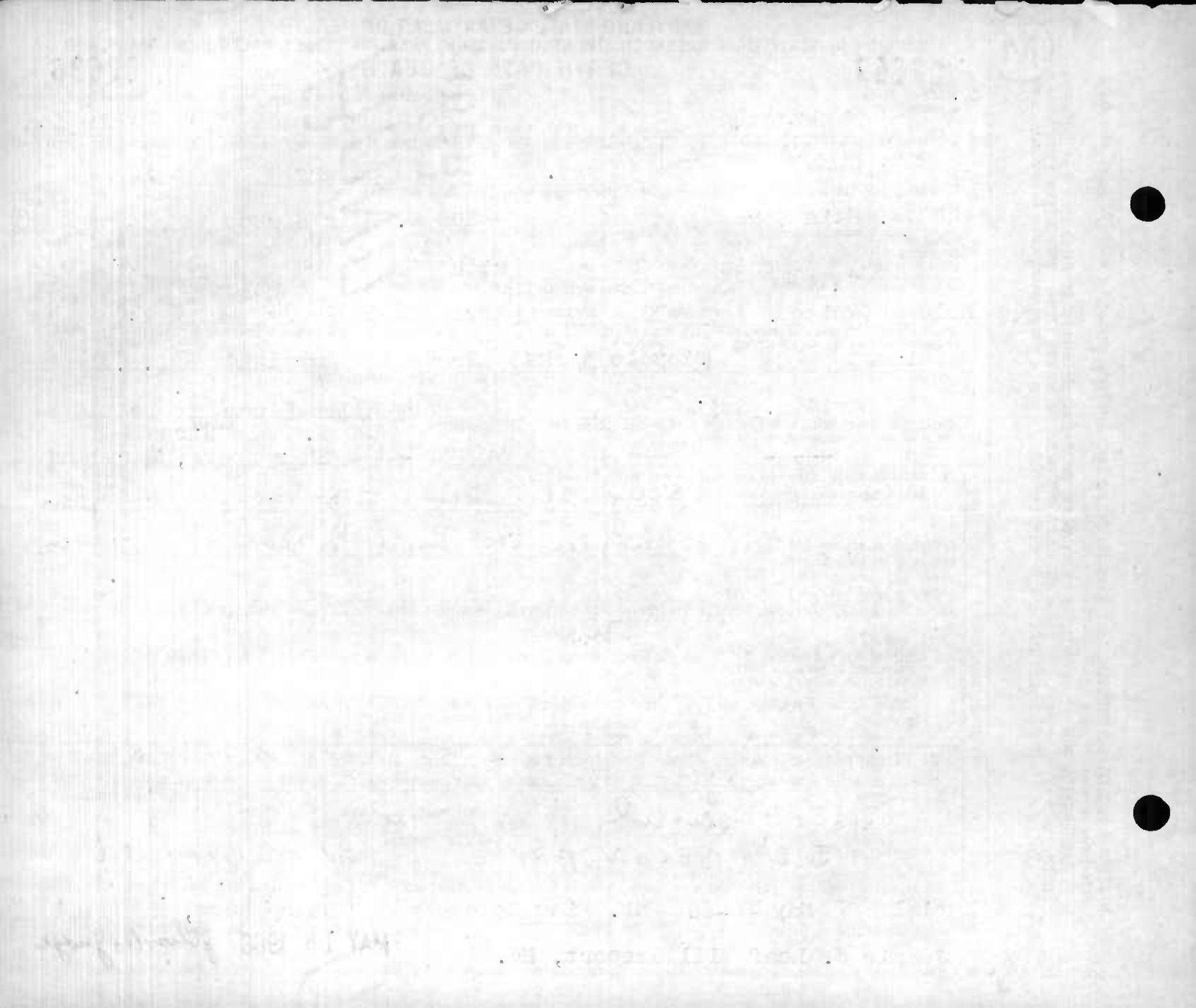
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. CDUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> <span style="float: right;">c. LENGTH OF STAY IN 1b</span> <u>50 yrs.</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> <span style="float: right;">21-1</span> d. STREET ADDRESS <u>200 E. Main Street</u>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Louis R Smith</u> First Middle Last						<b>4. DATE OF DEATH</b> <u>May 14 1966</u> Month Day Year					
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 16 1872</u> <span style="float: right;">94</span> yrs.		<b>9. AGE</b> (In years last birthday) <u>94</u> <span style="float: right;">yrs.</span>		<b>IF UNDER 1 YEAR</b> <u>0</u> <b>Months</b> <u>20</u> <b>Days</b> <u>0</u> <b>Hours</b> <u>0</u> <b>Min.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Machinest</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Bicycle Works</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Frederick Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>			
<b>13. FATHER'S NAME</b> <u>David M. Smith</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ellen Piper</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> (If yes give war or dates of service) <u>None</u>		<b>17. INFORMANT</b> <u>Grafton Smith</u> <span style="float: right;">Address</span> <u>200 E. Main Street</u> <u>Sharpsburg, Maryland</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u> <u>4200</u> DUE TO (b) <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>None</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>17 years</u> <u>years</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>None</u>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>DR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> <u>19</u> <span style="float: right;">Hour a.m. p.m.</span>		<b>20d. INJURY OCCURRED</b> <u>While at work</u> <input type="checkbox"/> <b>Not While at work</b> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2-5-</u> , 19 <u>60</u> , <b>to</b> <u>5-14</u> , 19 <u>66</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>5-14-</u> 19 <u>66</u> , <b>and that death occurred at</b> <u>1 P</u> M, <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>JOSEPH SECUNDARI</u> <span style="float: right;">M.D.</span>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>5-16-66</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>JOSEPH SECUNDARI</u>						<b>22d. ADDRESS</b> <u>Boonsboro Md</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>May 17-66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. View Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Sharpsburg, Maryland</u>		<b>(State)</b>			
<b>24. FUNERAL DIRECTOR</b> <u>Jennie E. Leaf Williamsport, Md.</u> <span style="float: right;">ADDRESS</span>						<b>25a. RECD BY REGISTRAR</b> <u>MAY 18 1966</u> <span style="float: right;">DATE</span>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>44 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>21-1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>					d. STREET ADDRESS <u>408 N. Prospect St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Oliva</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30, 1893</u>		9. AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Berkeley Springs, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Nelson Smith</u>					14. MOTHER'S MAIDEN NAME <u>Margaret Delena Butts</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>213-24-9785</u>		17. INFORMANT Address <u>Mrs. Emma R. King 418 Boward St. Hagerstown, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> 330x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis and</u> DUE TO (c) <u>rupture of aneurysm</u> 20 yrs								INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>May 18, 1966</u> , to <u>May 24, 1966</u> , that (I) (we) last saw the deceased alive on <u>May 24, 1966</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Edward W. Ditto III</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/25/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>					22d. ADDRESS <u>217 W. Washington St., Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>			
24. FUNERAL DIRECTOR <u>Wm. C. Hoff</u>					25a. REC'D BY REGISTRAR <u>MAY 31 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		
24. FUNERAL DIRECTOR <u>Rest Haven Funeral Chapel</u>					24. FUNERAL DIRECTOR <u>Hagerstown, Md.</u>				

1916

Washington

Department

Washington, D.C.

Office

Room

July 20, 1916

72

Washington

Room 100

Washington, D.C.

John Nelson Smith

Washington, D.C.

213-34-1787

Washington, D.C.

10

Washington, D.C.

Washington, D.C.

Washington, D.C.

John D. Smith

Washington, D.C.

Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>						c. LENGTH OF STAY IN 1b <b>35 DAYS</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>						d. STREET ADDRESS <b>335 N. LOCUST STREET</b>					
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>MAY</b> Last <b>SNODDERLY</b>						4. DATE OF DEATH Month <b>MAY</b> Day <b>23</b> Year <b>19 66</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 24, 1888</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FRANKLIN CO., PENNA.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MARTIN L. DUNLAP</b>						14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>HAGERSTOWN, MARYLAND</b> <b>MRS. RUBY RIDENOUR R.D. # 5</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE SECOND CONDITION GIVEN IN PART I (a) <b>Chronic Venous Thrombosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>2-13</b> , 19 <b>61</b> , to <b>5-23</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5-24</b> , 19 <b>66</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>E.R. IARDIZABAL</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/24/1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>E.R. IARDIZABAL M.D.</b>						22d. ADDRESS <b>300 N. POTOMAC ST. HAGERSTOWN, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>5/25/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LETTERSBURG LUTHERAN CEM.</b>				23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <b>Charles R. Royer</b>						ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>MAY 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

200 70 YAM

222 Y. S. YAM



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

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20 M 1/66

M

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Funkstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Funkstown</b> 21-1	
c. LENGTH OF STAY IN lb <b>50 years</b>		d. STREET ADDRESS <b>106 E. Cemetery St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>106 E. Cemetery St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELVA</b> Middle <b>BERNICE</b> Last <b>SPIDLE</b>		4. DATE OF DEATH Month <b>May 11,</b> Day <b>19</b> Year <b>66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 1, 1885</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>fiddlersburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Riley R. Williams</b>		14. MOTHER'S MAIDEN NAME <b>Mary McCarter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Harry F. Spidle, Funkstown, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart D</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes - Gen. arteriosclerosis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 29, 1966</b> , to <b>May 11, 1966</b> that (I) (we) last saw the deceased alive on <b>May 11, 1966</b> , and that death occurred at <b>6:55 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>SIDNEY NOVENSTEIN</b>		22b. DATE SIGNED <b>5-12-66</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Funkstown Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-14-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Funkstown, Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Funkstown, Md.</b>	
24. FUNERAL DIRECTOR <b>minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 17 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			

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FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07651

07640

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>37 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>374 Pangborn Blvd.</u>				d. STREET ADDRESS <u>374 Pangborn Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>William</u> Last <u>Stockslager Sr.</u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>19 66</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19, 1906</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sexton</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Church</u>		11. BIRTHPLACE (State or foreign country) <u>Chemsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles E. Stockslager</u>				14. MOTHER'S MAIDEN NAME <u>Naomi C. Black</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-5630</u>		17. INFORMANT <u>Mrs. C.W. Stockslager Sr.</u> Address <u>Hagerstown, Md.</u> <u>374 Pangborn Blvd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>9731</u> IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning.</u> Possibly <u>20</u> DUE TO <u>Minutes.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Due to illness patient was very depressed the past two months.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>5-4-66</u>	
				Address (Street, city, town, or county) <u>Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/5/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Horst</u> <u>Rest Haven Funeral Chapel</u>				25a. REC'D BY REGISTRAR <u>Hagerstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Mr. C. Hunt

07652

## CERTIFICATE OF DEATH

07641

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GILBERT RENO THOMAS</b>		4. DATE OF DEATH <b>May 6 19 66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/13/04</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>burner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sand blasting</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Sharpsburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Franklin H. Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Susie Baker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mable P. Thomas</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary oedema re-occurring</b> 4201 DUE TO <b>Acute coronary occlusion (anterior) with</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>myocardial infarction</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>17 1/2 hours</b> <b>17 1/2 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Previous coronary occlusion (posterior) with myocardial infarction</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May 6</b> , 19 <b>66</b> , to <b>May 6</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>May 6</b> , 19 <b>66</b> , and that death occurred at <b>8:03 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>W. T. Layman, M.D.</b>		22b. DATE SIGNED <b>May 7, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>		22d. ADDRESS <b>00 Professional Arts Bldg. Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>5/9/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Md.</b>
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>MAY 11 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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GENERAL INQUIRY

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NAME: [illegible] ADDRESS: [illegible] CITY: [illegible] STATE: [illegible] ZIP: [illegible]

DATE OF BIRTH: [illegible] SEX: [illegible] RACE: [illegible] RELIGION: [illegible]

EDUCATION: [illegible] OCCUPATION: [illegible] MARITAL STATUS: [illegible]

PREVIOUS RESIDENCES: [illegible] CURRENT RESIDENCE: [illegible]

DATE OF ENTRY: [illegible] DATE OF DEPARTURE: [illegible]

REASON FOR ENTRY: [illegible] REASON FOR DEPARTURE: [illegible]

DATE OF BIRTH: [illegible] SEX: [illegible] RACE: [illegible] RELIGION: [illegible]

EDUCATION: [illegible] OCCUPATION: [illegible] MARITAL STATUS: [illegible]

PREVIOUS RESIDENCES: [illegible] CURRENT RESIDENCE: [illegible]

DATE OF ENTRY: [illegible] DATE OF DEPARTURE: [illegible]

REASON FOR ENTRY: [illegible] REASON FOR DEPARTURE: [illegible]

DATE OF BIRTH: [illegible] SEX: [illegible] RACE: [illegible] RELIGION: [illegible]

EDUCATION: [illegible] OCCUPATION: [illegible] MARITAL STATUS: [illegible]

PREVIOUS RESIDENCES: [illegible] CURRENT RESIDENCE: [illegible]

DATE OF ENTRY: [illegible] DATE OF DEPARTURE: [illegible]

REASON FOR ENTRY: [illegible] REASON FOR DEPARTURE: [illegible]

DATE OF BIRTH: [illegible] SEX: [illegible] RACE: [illegible] RELIGION: [illegible]

EDUCATION: [illegible] OCCUPATION: [illegible] MARITAL STATUS: [illegible]

*Handwritten signature*

MAY 11 1955



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM (5)  
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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>16 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>145 Ray St.</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>145 Ray St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Norman Lee Thomas</b>		4. DATE OF DEATH <b>May 11, 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1895</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>27</b>	11. IF UNDER 24 HRS. Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Sharpsburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward F. Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Annie C. Lumm</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>214-32-3830</b>	
17. INFORMANT <b>Donald A. Thomas Rfd. 1 Boonsboro, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Strangulation</b> 974x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Suicide</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Patient hung himself in garage.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>12:20 5/11/66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hagerstown Wash. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Howard N. Weeks</b> EXAMINER'S NAME (Type) <b>Howard N. Weeks, M. D.</b>		22. DATE SIGNED <b>5/13/66</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>580 Northern Ave., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-14-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mountain View Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Sharpsburg, Md.</b>	
24. FUNERAL DIRECTOR <b>John H. Bast, Jr.</b>		25. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>112 N. Main St. Boonsboro, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

07654

07643

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Washington</span> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Md.</span> b. COUNTY <span style="font-size: 1.2em;">Wash.</span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Hagerstown</span>		c. LENGTH OF STAY IN lb <span style="font-size: 1.2em;">2 weeks</span>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">Washington County Hospital</span>		e. STREET ADDRESS <span style="font-size: 1.2em;">RFD 3</span>	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="font-size: 1.2em;">THOMAS WAYNE TREMBATH</span>		<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">May</span> Day <span style="font-size: 1.2em;">10,</span> Year <span style="font-size: 1.2em;">19 66</span>	
5. SEX <span style="font-size: 1.2em;">male</span>	6. COLOR OR RACE <span style="font-size: 1.2em;">white</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">May 29, 1893</span>
9. AGE (In years last birthday) <span style="font-size: 1.2em;">72</span> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">supervisor</span>		10b. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">public education</span>	
11. BIRTHPLACE (County & State, or foreign country) <span style="font-size: 1.2em;">Kingston, Penna.</span>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <span style="font-size: 1.2em;">William J. Trembath</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Sarah Colley</span>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <span style="font-size: 1.2em;">no</span>		16. SOCIAL SECURITY NO.	
17. INFORMANT <span style="font-size: 1.2em;">Mrs. Mary Trembath, Hagerstown, Md.</span>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Uremia</span> DUE TO (b) <span style="font-size: 1.2em;">Nephrosclerosis &amp; Hypotension</span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <span style="font-size: 1.2em;">Generalized Arteriosclerosis Paralysis Agitation</span>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">4 Day</span>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <span style="font-size: 1.2em;">19</span>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">4/24/66</span> , 19__, to <span style="font-size: 1.2em;">5/10/66</span> , 19__, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">5/10/66</span> , 19__, and that death occurred at <span style="font-size: 1.2em;">8:00 P.</span> M, from causes and on the date stated above.			
22a. SIGNATURE <span style="font-size: 1.2em;">Robert V. H. Campbell</span> M.D.		22b. DATE SIGNED <span style="font-size: 1.2em;">5/11/66</span>	
22c. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Robert V. H. Campbell</span>		22d. ADDRESS <span style="font-size: 1.2em;">Hagerstown Md.</span>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">burial</span>	23b. DATE THEREOF <span style="font-size: 1.2em;">5-14-66</span>	23c. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">St. Mark's Cemetery</span>	23d. LOCATION (City or Town) (County) (State) <span style="font-size: 1.2em;">Lappans, Wash. Co., Md.</span>
24. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Minnich Funeral Home, Hagerstown, Md.</span>		25a. REC'D BY REGISTRAR <span style="font-size: 1.2em;">MAY 17 1966</span>	
25b. REGISTRAR'S SIGNATURE <span style="font-size: 1.2em;">Charles Judge</span>		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 20 M 1/66

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <i>Washington</i>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		c. LENGTH OF STAY IN 1b <i>Most of life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Western Maryland State Hospital</i>		d. STREET ADDRESS <i>234 E. Washington St.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>JESSIE LOUISE VINCENT</i>		4. DATE OF DEATH Month Day Year <i>MAY 25 1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN 26, 1913</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Resturant</i>	9. AGE (In years last birthday) <i>53</i>
11. BIRTHPLACE (County & State, or foreign country) <i>Middleburg, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Edward Stotler</i>		14. MOTHER'S MAIDEN NAME <i>Prudence Nora Brumbaugh</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-09-6388</i>	
17. INFORMANT <i>O.D. Vincent</i>		Address <i>234 E. Washington St. Hagerstown, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>UREMIA</i> <i>1810</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>CARCINOMA OF BLADDER</i> DUE TO (c) <i>3 MONTHS</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 MONTH</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>NON-FUNCTIONING LEFT KIDNEY- HYDRONEPHROSIS OF RT. KIDNEY</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>4-20 - 1966</i> to <i>5-25 - 1966</i> , that (I) (we) last saw the deceased alive on <i>5-25 - 1966</i> , and that death occurred at <i>4:08</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Antonio U. Pallagrosi</i>		22b. DATE SIGNED <i>5-25-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>ANTONIO U. PALLAGROSI</i>		22d. ADDRESS <i>1500 Penn Ave Hagerstown</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5/28/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Hagerstown Md.</i>
24. FUNERAL DIRECTOR <i>Wm. C. Hunt</i>		25. REC'D BY REGISTRAR <i>MAY 31 1966</i>	
Address <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>g Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 1/2</u> Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cascade</u> d. STREET ADDRESS <u>21-1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Clay</u> Middle <u>E.</u> Last <u>Willard</u>						4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1966</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 16, 1905</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Waynesboro Knitting Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Blue Ridge Summit Pa.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Clay E. Willard Sr.</u>						14. MOTHER'S MAIDEN NAME <u>Bessie Barton Tracey</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>162-05-6190</u>		17. INFORMANT Address <u>Fla. Miss Katherine T. Willard, St. Petersburg</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> <u>5810</u> DUE TO (b) <u>Portal Cirrhosis, advanced</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <u>Uncertain</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>5-7, 1966</u> , to <u>5-8, 1966</u> , that (I) (we) last saw the deceased alive on <u>5-8-1966</u> , and that death occurred at <u>12:15</u> AM, from the causes and on the date stated above.													
22a. SIGNATURE <u>John H. Hornbaker</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-9-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>						22d. ADDRESS <u>154 West Washington St., Hagerstown, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>			23d. LOCATION (City, town or county) (State) <u>Waynesboro, Franklin Co. Pa.</u>				
24. FUNERAL DIRECTOR <u>Katherine G. Jones</u>				ADDRESS <u>Waynesboro, Pa.</u>		25a. REC'D BY REGISTRAR <u>MAY 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

STATE OF TEXAS

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John H. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07657

07646

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>119 E. Washington St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>TILGHMAN</u> <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Jan. 21, 1876</u> <b>9. AGE</b> (In years last birthday) <u>90</u> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Fireman - Retired</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>M. P. Moller, Inc.</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Altoona, Pa.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>4. DATE OF DEATH</b> <u>May 1, 1966</u> <b>13. FATHER'S NAME</b> <u>Tilghman W. Williams</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Matilda Reese</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>214-09-1121</u> <b>17. INFORMANT</b> <u>Mrs. Dorothy Farrand</u> <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <u>324 N. 36th. St, Camp Hill, Pa.</u> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Arteriosclerosis, gen.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>?</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>Yes.</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>	
<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> <u>55th 24</u> (County) <u>1962</u> (State) <u>to May 1966</u>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>55th 24</u> <u>1962</u> <u>to May 1966</u> , that (I) (we) last saw the deceased alive on <u>1 May 1966</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.	
<b>22a. SIGNATURE</b> <u>[Signature]</u> M.D.		<b>22b. DATE SIGNED</b> <u>2 May 66</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>W. N. FENDER</u>		<b>22d. ADDRESS</b> <u>218 N. Potomac St. Hagerstown, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>5/3/66</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> <u>Hagerstown, Md.</u> (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>A. K. Coffman</u> ADDRESS <u>Funeral Home, Inc.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>MAY 6 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>	

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## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07647

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>—</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BARRY WAYNE WITMER</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>22</u> Year <u>1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/23/1943</u>
9. AGE (In years last birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Flagg Bros. Manager Shoe Retail</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chambersburg, Pa.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John L. Witmer</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Sites</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>160-36-2909</u>	
17. INFORMANT <u>John. Margaret Witmer -</u>		Address <u>Richmond Furnace, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture Of Skull</u> DUE TO (c) <u>Fracture Of Femur</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Car came in contact with curb &amp; striking a utility pole</u> <u>Failed to make curve on Pennsylvania Avenue.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>3</u> <u>5-22-</u> <u>1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Hagerstown, Washington, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>L. E. W. Ditto, Jr.</u>		22. DATE SIGNED <u>5-23-66</u>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		Address (Street, city, town, or county) <u>Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE THEREOF <u>5/24/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Greencastle, Pa.</u>	
24. FUNERAL DIRECTOR <u>A. E. Minnich - Greencastle, Pa.</u>		25a. REC'D BY REGISTRAR <u>MAY 26 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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## CERTIFICATE OF DEATH

07648

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>		c. LENGTH OF STAY IN 1b <b>3 weeks</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Reeder Nursing Home</b>		d. STREET ADDRESS <b>236 E. Antietam St.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>EUGENE</b> Last <b>WOLFE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>19 66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/14/04</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>brimmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>shoe mfg.</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Leitersburg, Md.</b>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Harvey Wolfe</b>		14. MOTHER'S MAIDEN NAME <b>Cora DeLauder</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>719-14-1693</b>	17. INFORMANT <b>Bertha E. Wolfe</b> Address <b>Hagerstown, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> 4500 DUE TO (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Congenital Mental Retardation</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5-3</b> , 19 <b>66</b> , to <b>5-23</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>5-22</b> , 19 <b>66</b> , and that death occurred at <b>10:4</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Robert P. Conrad</b>		22b. DATE SIGNED <b>5-24-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert P. Conrad</b>		22d. ADDRESS <b>137 W. Washington Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REINTERMENT	23b. DATE THEREOF <b>5/26/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>
24. FUNERAL DIRECTOR <b>MINNICH FUNERAL HOME, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 26 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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07660

CERTIFICATE OF DEATH

07649

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>2 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Paramount</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>21-1</b>	
3. NAME OF DECEASED (Type or print) First <b>IVA</b> Middle <b>PEARL</b> Last <b>WOLFE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 66</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1892</b>
9. AGE (In years last birthday) <b>73 yrs.</b>		IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b>	IF UNDER 24 HRS. Hours <b>73</b> Min. <b>73</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Washington Co., Md.</b>
13. FATHER'S NAME <b>Charles B. Nigh</b>		14. MOTHER'S MAIDEN NAME <b>Arena Neikirk</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none 1</b>	
17. INFORMANT <b>Roy N. Wolfe, Paramount, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446X</b> DUE TO <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>generalized arteriosclerotic heart disease</b> (c) <b>myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Coronary Artery Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-2</b> , 19 <b>66</b> , to <b>5-5</b> , 19 <b>66</b> , that (I) (we) last saw the deceased give an <b>5-5-66</b> 19 <b>66</b> , and that death occurred at <b>11:30 p.m.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>E. R. Lutz</b>		22b. DATE SIGNED <b>5-5-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>E. R. Lutz</b>		22d. ADDRESS <b>300 North Potomac, Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5-8-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>
23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>		23e. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 9 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CHURCH OF DEATH

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Foramont

Washington County Hospital

1914

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Female - white

June 1, 1902

Washington Co., N.Y.

Washington Co., N.Y.

Washington Co., N.Y.

Attest: [Signature]

1900

By J. J. [Signature]

Washington Co., N.Y.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07661

## CERTIFICATE OF DEATH

07650

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		d. STREET ADDRESS <b>29 Randolph Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>Susan</b> Last <b>Wolfe</b>		4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 29, 1887</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>The Manor, Wash. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John S. Wolfe</b>		14. MOTHER'S MAIDEN NAME <b>Ella Yourtee</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>314-09-1627</b>	
17. INFORMANT <b>Mrs Mary K. Neikirk</b>		Address <b>Dewey Ave. Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the liver</b> DUE TO (b) <b>Not known</b> DUE TO (c) <b>Not known</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 9, 1966</b> , to <b>May 22, 1966</b> , that (4) (we) last saw the deceased alive on <b>May 22, 1966</b> , and that death occurred at <b>8:30 P.</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <i>B. B. Kneisley</i>		22b. DATE SIGNED <b>5/23/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. B. Kneisley, M.D.</b>		22d. ADDRESS <b>148 West Washington Street Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 25 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Manor Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Tilghamton, Md Wash. Co., Md</b>	
24. FUNERAL DIRECTOR <b>Andrew K Coffman Funeral Home Inc. Hagerstown, Maryland</b>		25. REC'D BY REGISTRAR <b>MAY 26 1966</b>	
26. REGISTRAR'S SIGNATURE <i>James J. Judge</i>		27. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and may event, within 72 hours after death.

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Continuation of the river

A. R. Kneale, N.B.

May 20 1906



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			c. LENGTH OF STAY IN 1b <b>26 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>					d. STREET ADDRESS <b>158 S. PROSPECT ST.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>WIE</b>		Middle <b>TOWSEND</b>		Last <b>WROTH</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>1</b> Year <b>19 66</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 24, 1879</b>		9. AGE (In years last birthday) <b>87</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>STEUBEN CO., NEW YORK</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>SAMUEL J. LOWER</b>					14. MOTHER'S MAIDEN NAME <b>MARY NORTON</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>1645 POUNT HD. RD. MRS. JOHN V. JAMISON III HAGERSTOWN, MD.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Arteriosclerotic heart disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour <b>e.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1</b>		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>April 4, 1966</b> , to <b>May 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>May 1, 1966</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.										
22a. SIGNATURE <b>Ralph S. Stauffer</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5/2/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>RALPH S. STAUFFER M.D.</b>					22d. ADDRESS <b>145 S. PROSPECT ST. HAGERSTOWN, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/3/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>HAGERSTOWN, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>Charles M. Reizer</b>				ADDRESS <b>HAGERSTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>MAY 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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CERTIFICATE OF DEATH

07663

07652

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxen H-11</u>	
c. LENGTH OF STAY IN 1b <u>2 yrs.</u>		d. STREET ADDRESS <u>16-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Maryland State Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis Demetris Xoxakos</u>		4. DATE OF DEATH <u>5-31-66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-91</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>31</u> Hours <u>16</u> Min. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner-operator</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kalamata Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>no</u>	
13. FATHER'S NAME <u>Demetris Xoxakos</u>		14. MOTHER'S MAIDEN NAME <u>no record</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Callie Kublin</u>		Address <u>318 Summit Ave. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 4500 DUE TO (b) <u>Arteriosclerosis, General</u> DUE TO (c) <u>not known</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-13</u> , 19 <u>66</u> , to <u>5-31</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>5-31-1966</u> , and that death occurred at <u>11:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>FRANCISCO RIEGO</u>		22b. DATE SIGNED <u>5-31-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCISCO RIEGO</u>		22d. ADDRESS <u>1500 Penn. Ave. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>6-4-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Benedictine Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Savannah Chatham Co Ga</u>
24. FUNERAL DIRECTOR <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR <u>SUN 6 1966</u>	
ADDRESS <u>Hagerstown Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

32048

STATE OF MICHIGAN

48070

<p>TO THE HONORABLE CLERK OF THE SUPREME COURT          STATE OF MICHIGAN          LANSING, MICHIGAN</p>	
<p>PLEASE TAKE NOTICE that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Court.</p>	
<p>IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Court at Lansing, Michigan, this _____ day of _____, 19____.</p>	
<p>_____          CLERK OF THE COURT</p>	<p>_____          ATTORNEY AT LAW</p>
<p>FILED FOR RECORD IN THE OFFICE OF THE CLERK OF THE SUPREME COURT, STATE OF MICHIGAN, AT LANSING, MICHIGAN, THIS _____ DAY OF _____, 19____.</p>	
<p>_____          CLERK OF THE COURT</p>	

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THIS DOCUMENT IS THE PROPERTY OF THE CLERK OF THE SUPREME COURT, STATE OF MICHIGAN, AND IS TO BE KEPT IN THE OFFICE OF THE CLERK OF THE SUPREME COURT, STATE OF MICHIGAN, AT LANSING, MICHIGAN. IT IS TO BE RETURNED TO THE CLERK OF THE SUPREME COURT, STATE OF MICHIGAN, AT LANSING, MICHIGAN, UPON THE REQUEST OF THE CLERK OF THE SUPREME COURT, STATE OF MICHIGAN, AT LANSING, MICHIGAN.